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UNTIE THE ELDERLY: QUALITY CARE WITHOUT RESTRAINTS

SYMPOSIUM

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS
FIRST SESSION

WASHINGTON, DC

DECEMBER 4, 1989

Serial No. 101-H

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PREFACE

On December 4, 1989, the U.S. Senate Special Committee on Aging sponsored a national symposium entitled "Untie the Elderly: Quality Care Without Restraints." The overwhelming interest in this forum demonstrated to the Committee the groundswell of support for eliminating—or significantly reducing—the use of restraints in our Nation's nursing homes.

The Federal Government will play a key role in supporting the establishment of restraint-free, or at least restraint-reduced environments. In 1987, Congress passed sweeping nursing home reforms that were incorporated into the Omnibus Budget Reconciliation Act (OBRA), to address the need for quality patient care. OBRA '87 outlined the importance of individual residents' needs, wants, and desires in determining the quality of care.

These reforms also included strengthened patient rights concerning the use of restraints imposed "for the purposes of discipline or convenience, and not required to treat the resident's medical symptoms." While the OBRA provisions must be enforced by the States by the fall of 1990, an estimated 50 percent of all nursing home residents are currently restrained in some form. This broad disparity between impending regulatory standard and common practice was a primary motivation for the Committee's symposium.

Enactment of a law, however, is only a partial answer. We also have a responsibility to provide leadership and information to all affected parties. The Committee symposium provided an opportunity to closely examine national practices regarding the use of restraints, and to assess the viability of establishing restraint-free environments in health care facilities. By bringing together professionals, academicians, consumers, Members of Congress and their staffs and other interested individuals, we were able to discuss alternatives to restraining our Nation's disabled and elderly.

The Aging Committee is pleased to release this print, which contains the proceedings of the symposium, as well as related materials on the use of restraints. We would like to express our appreciation to everyone who made this event possible, with special thanks to the Kendal Corporation of Kennett Square, Pennsylvania.

David Pryor,
Chairman.
John Heinz,
Ranking Minority Member.

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UNTIE THE ELDERLY: QUALITY CARE WITHOUT RESTRAINTS

MONDAY, DECEMBER 4, 1989

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The Committee met in room 216, Hart Senate Office Building, Senator John Heinz presiding.

Present: Senator Heinz.

Staff present: Christopher C. Jennings, deputy staff director; William Benson, chief of health and housing policy; Holly Bode, professional staff; and Bonnie Hogue, professional staff.

OPENING STATEMENT OF SENATOR HEINZ

Senator HEINZ. Ladies and gentlemen, may I have your attention, please?

Good morning. I'm Senator John Heinz, the ranking member on the Senate Special Committee on Aging. I'm very pleased and honored to welcome all of you here on behalf of my chairman, Senator David Pryor of Arkansas, with whom I'm privileged to co-chair the Special Committee on Aging. Both of us have had a long and very deep interest in issues such as the quality of nursing home care. Indeed, when I came to the House of Representatives in November 1971, Senator Pryor first came to national prominence investigating a nursing home in Homesdale, PA, when he was a Member of the House.

He attempted to start a Committee on Aging in the House. He was told there was no room for that committee. It was my privilege to undertake that effort. I was the author of the legislation that created the House Committee on Aging, and Senator Pryor and I reunited our efforts here in the Senate where he finally arrived shortly after I did.

I want to, on his behalf, therefore, welcome all of you here to this symposium on nursing home care without restraints.

This issue is centered around the crucial importance of preserving an individual's human rights and the tenuous balance between self-determination and benevolent paternalism.

I'm hopeful that today we can shed some light on the conflict between the rights of the elderly to take risks and the desire of their caregivers to, understandably, minimize those risks. But, as we all know, risks are an inherent part of life. I suppose that one way we could all have minimized the risk on getting here this morning is to have driven in tanks, but we didn't. We drove in, for the most part, in automobiles. I know of one or two staff members who come to work either on motorbikes or on bicycles. Clearly, the risk of injury would be substantially offset if we drove something other than fragile cars and chose armored personnel carriers instead.

For the frail and ill, our policies and practices determine the type and extent of risk that is allowed in our hospitals and nursing homes. Understanding that we can't allow dangerous neglect in the name of freedom, we also have to try to assess accurately the amount of risk that actually exists and be aware of the new problems created by our solutions. You might say that the danger of ignoring human rights and, therefore, dehumanizing people who have every right to be proud, senior citizens, is danger that is difficult to gauge. Nevertheless, it may pose a greater threat to providing quality care than the risk of physical injury, itself.

Now, we all know that physical restraints have often been accepted as a solution to risks in nursing homes. It has been common practice to use restraints to keep residents in their beds or in their wheelchairs or to use tranquilizers and sedatives to quell their desire to get up and walk.

When restraints are used, certainly the patient can't walk and can't fall down. But at what cost? All too often the patient deteriorates much more rapidly and sacrifices his or her physical and mental health, their vitality, and, most of all, their human dignity—all in the name of avoiding risks.

I'd like to share with you a true story of the dilemma posed by the use of such restraints.

Mr. H—no relation—is an 83-year-old nursing home resident. He is recovering from a hip fracture. He is reluctant to participate in the structured activity of physical therapy, so his progress is slow. Nevertheless, he tries to make the short walks alone from the wheelchair to the bed, to the bathroom. One evening he falls on one of his short journeys.

The staff tells him to try not to walk when he's alone. The next day he tries it again and he falls and he suffers a minor cut on the head. Despite all the warnings he is given by the staff, he won't stop trying.

And so the nursing home makes the decision to restrain Mr. H. He is belted into a chair, though he protests vigorously and tugs at the restraints and begs passers-by to untie him.

The nurse says, "It is for your own good." And she really means it. But is it for his own good? How much risk-laden independence should caregivers practice?

We need to bring open minds to this reassessment.

Just last night I told an acquaintance about today's symposium and my friend expressed surprise and skepticism—really great skepticism—that you could have a nursing home where providers would manage effectively without restraint. Indeed, I think the conventional wisdom is that physical and chemical restraining of many nursing home residents is an unavoidable fact of life.

The purpose of this symposium is to demonstrate that the conventional wisdom is wrong and that there are humane, caring alternatives to strapping residents into wheelchairs and beds. And we will also explore what is necessary in the way of attitude, skills, and resources to provide nursing home care with dignity; and we will examine in equal detail and attention, I hope the barriers—medical, legal, and practical—to treating residents with the care and kindness they deserve.

Before I close I want to recognize the organization—I'm very proud that it is from my home State of Pennsylvania—which has been instrumental in preaching the gospel of restraint-free care, and not only preaching but practicing what they preach. This organization is the Kendal Corporation. It is in southeast Pennsylvania. They operate continuing care retirement communities throughout that southeastern quadrant of our State. They are committed to preserving senior citizens' basic human rights and providing quality life and health care. Fifteen years ago that commitment led them to begin providing care without restraints, and their efforts continue today.

I think you could say that theirs is literally a cutting edge attempt to achieve quality care by striking a new balance between absolute safety and respect for the individual's dignity and human rights.

So I want to salute the Kendal Corporation for being here. I bid its representatives, including their chairman and his wife, Margo, a special welcome here today.

You have looked at the agenda. You see that we have assembled an extraordinary group of experts to discuss and weigh the risks against the possible solutions. Senator Pryor and I and the members of the U.S. Senate Special Committee on Aging look forward to the testimony of our distinguished speakers on the agenda today.

At this point I want to turn whatever part the committee will play here from here on out over to the deputy staff director of the committee, Chris Jennings.

Chris.

STATEMENT OF CHRISTOPHER JENNINGS, DEPUTY STAFF DIRECTOR, SPECIAL COMMITTEE ON AGING

Mr. **Jennings**. Senator Heinz is a modest man. He has been a leader in quality of care improvements in nursing homes for decades. I think we should all, before he leaves, give him a round of applause.

[Applause.]

Mr. **Jennings**. On behalf of Senator Pryor, I'd like to join Senator Heinz in extending his welcome to today's jointly sponsored Senate Aging Committee-Kendal Corporation Symposium on the use of restraints in nursing homes.

As Senator Heinz said, I'm Chris Jennings, deputy staff director of the Senate Aging Committee.

Senator Pryor asked me to send his deep regrets about not being here today. As Senator Heinz mentioned, he gained his notoriety in the aging field by going undercover as an orderly to uncover nursing home quality shortcomings in the early 1970's. Since then we have come a good ways, and he wanted to be the first to note that today. He also wanted to be here to work with you to see if there could be ways we could further improve quality of care in nursing homes.

Unfortunately for all of us, Senator Pryor wears several hats. Not only is he Chairman of the Aging Committee, he is secretary of the Democratic Conference, Chairman of the Senate Finance Subcommittee, Chairman of the Governmental Affairs Subcommittee, ranking member of the Senate Agricultural Committee, and, most important, he is a member up for reelection next year. The latter two responsibilities forced him out of town today—a development that I know he greatly regrets.

Somehow we will find a way to proceed. As a starter, I'd like to give you a little bit of background on how this symposium came about.

The Kendal Corporation, located in Pennsylvania, is a not-for-profit organization which operates long-term care facilities for the elderly. Several months ago, staff from Kendal met with the Aging Committee staff to discuss their program entitled "Untie the Elderly."

For 16 years Kendal has not used restraints in their nursing homes and has demonstrated that safe, quality, cost-effective care can be achieved without the use of restraints. Because of their success in eliminating the use of physical restraints, Untie the Elderly was begun. This program is designed to increase public awareness of the damaging effects of restraints and to offer support and guidance to facilities interested in facilitating restraint-free care.

As Senator Heinz mentioned, the Senate Aging Committee has a longstanding history of involvement in nursing home quality of care. Our staff, therefore, was very interested in working with Kendal, seeing what they were doing, and we began to explore possible roles for the Aging Committee to examine and focus attention on this issue.

While a traditional avenue for publicizing an issue is a Congressional hearing, Chairman Pryor and Senator Heinz wanted to explore it in a different format. They chose a symposium as the best way to take an important first step towards educating, networking, and helping begin to form public policy about the restraints issue.

Today's first step is an impressive one. We are pleased that upwards of 400 people have signed up and are expected to be attending today. I know that many of you have come a long way, so I won't waste too much more valuable time. However, before I conclude I do want to thank the Kendal Corporation for all their hard work. This definitely could not have come about without them.

I also want to thank the Planning Committee, which is composed of providers, advocates, academicians, regulators, and the Aging Committee staff. They all take credit for organizing this symposium.

For just a brief moment I'd like to thank the Aging Committee staff, in particular, who have worked very hard and diligently. With Kendal, this could not have come about without them. That includes both the minority staff and the Aging Committee staff. On my staff it was Bill Benson, Kathy Sykes, Bonnie Hogue, Heather Dreyer, and Christine Drayton. But, in particular, I would like to single out Holly Bode, for she definitely worked for hours and hours and hours in getting this event together. Obviously it is going to be very successful, and I'd like to give 1 second of applause for her.

[Applause.]

Mr. **Jennings**. You represent an impressive array of interested parties, and your contributions will not only make today a success, but will assure the success of the committee print we will be releasing next year from these proceedings. I hope you all will write in and get a copy.

I would like to for one moment step back and review the recent developments in Eastern Germany and throughout the world and note and appreciate the winds of change. In this vein it is my hope that we can start making a few changes in the quality of care nursing home recipients are receiving today. I think today's symposium is a good step in that direction.

Right now I would like to turn this over to Lloyd Lewis of the Kendal Corporation to get us going.

Thank you very much.

STATEMENT OF LLOYD LEWIS, KENDAL CORP.

Mr. **Lewis**. Thank you very much. It is a great pleasure to be here this morning and to have so many of you gathered here to listen and to discuss this critical issue.

I was interested in the allusion to what is going on in Eastern Europe because the winds of change are bringing about the elimination of many restraints in Eastern Europe, too. Perhaps we can take that spirit and keep that going right here.

We will open the program this morning with a testimonial from family members of a resident of a nursing facility that is making the transition to non-restraint care.

This will be followed this morning by Jill Blakeslee taking a philosophical look at the use of physical restraints and the need to change attitudes for implementing effective alternatives.

Then we will have a panel, which will present various concerns regarding restraint elimination.

Finally this morning will be a presentation on legal issues.

There will be a short break at 10 a.m., and then just prior to lunch we will try and have 15 minutes for questions and answers from the audience.

We hope to end this morning's session at 11:45 a.m. punctually, and lunch is on your own. A list of local restaurants has been included in your handout materials. I hope that will be helpful to you.

At 1 p.m. we will resume the program by examining some experiences of restraint-free care here in the United States and abroad; then we will move on to examine the direction of new Federal policy and conclude by looking toward the future for changing practice through training, education, and research.

We will close with a synthesis of the day's events, along with a call for action in the hope that this symposium will lead to futher initiatives to improve the care of our nation's frail elderly.

We have a full schedule for today. It is a very tight schedule, and we are asking all of the participants to adhere to a very strict time schedule. So I hope that when we do have the break and at lunchtime coming back that you will all be prompt so that we can be sure to give everyone a chance to present their particular points of view and their particular experiences.

We're going to begin this morning with the family testimonial. I'd like to introduce to you Keith Grant and Susan McTyier. They are the husband and daughter of Virginia Grant, a resident of Tel Hai Retirement Community, a long-term care facility that is working toward the elimination of physical restraints.

Mr. Grant is an independent businessman in the family contracting business. Mrs. McTyier is a wife and mother of three. This morning they will briefly share their experiences with the care of an individual with a diagnosis of Alzheimer's disease, nursing home placement, and restraint-free care.

Keith Grant and Susan McTyier

STATEMENT OF KEITH GRANT, HUSBAND OF NURSING HOME PATIENT

Mr. GRANT. Good morning ladies and gentlemen.

In 1982 the furthest thought from my mind was the selection of a nursing home for my wife, let alone the related problems of restraint policies and other considerations in the selection of this type of home.

My wife was an intelligent and active mother of five who loved, lived, and enjoyed life to the utmost who, after our third child, decided to get her bachelor of science in music, started college, and, after about 8 years, graduated summa cum laude. She started to teach piano and art and was active in church and community activities throughout her adult life.

Early in 1982 memory and personality changes extreme enough to warrant neurological evaluation appeared. After 3 or 4 months of extensive testing she was diagnosed as Alzheimer's. The diagnosis eventually proved correct, and the condition followed the typical course of this dementia.

I had to hire a full-time, live-in nurse's aide who lived with us for 3 years. It came to a point that the aide and caregiver could not cope at home with the situation. She would wander off, pick up things to eat anywhere—out in the road—hitchhike, stop cars.

So it came to the point where the family, after many discussions and conferences, arrived at the serious and very unsettling decision to institutionalize her. The job in the selection of this facility began, and our selection was Tel Hai at Honeybrook.

Now Sue, my daughter, will relate our experiences there to this date.

Thank you.

STATEMENT OF SUSAN McTYIER, DAUGHTER OF NURSING HOME PATIENT

Ms. McTYIER. As Dad already said, we put Mom in Tel Hai for her own safety. She was always a very active woman. One of our greatest concerns was that she would end up being restrained. We felt that would be very detrimental to her health and would hasten the development of her disease.

As Dad indicated, Mom would walk around and pick up all kinds of things and put them in her mouth. She picked up a tack one day and was chewing on it and didn't even realize her gums were bleeding. She'd pick up pieces of plants, debris on the floor, or garbage out of trash cans. She must have been driving the nursing staff crazy. We notice that Mom was physically restrained more often than not whenever we'd come in to visit.

Dad is there almost every evening, and I come in once or twice during the week when I can with my children to visit Mom and walk her around.

We had many conferences with the physical therapist trying to figure out something that we could do that would leave her ambulatory, yet keep her from picking things up. What we finally came up with was a type of plastic molded form fit to her hand which we secured with ace bandages so that she was unable to physically grab things. However, she was still able to walk around and flick the lights on and off in other resident's rooms. So I think the reason we probably found her restrained in the chair so often was because she was turning the lights off up and down the hall, and also walking out of the security doors on her floor.

We still found her tied down more than we wanted to, and too often when she was tied down with a lap belt, the restraints were also on her hands. This didn't make any sense because the purpose of the hand restraints was so she could stay ambulatory.

When she was sitting for hours in her chair she started chewing and swallowing pieces of her hand restraints, because there was no other way to expend her energy.

She seemed very upset, and so were we. Mom is no longer able to speak, but she would often look very angry or grumpy whenever we visited, and Dad often commented that it seemed as if she were saying, "Why are you doing this to me?"

Whenever we would remove the restraints her countenance changed and she became happy again.

After a period of time we noticed that her right hand was starting to atrophy. Although this may be a normal progression of the disease, we felt that more than likely the use of the hand restraints had something to do with it.

Since Tel Hai has adopted the use of the nonrestraint program, we have noticed a significant change in Mom. She has calmed down visibly. We have also noticed an overall happier atmosphere in the whole facility.

It used to disturb us when we'd walk in and hear the residents moaning and crying for help. Since the change, the noise level has dropped considerably.

Where there seemed to have been negative attitudes on the part of the residents that were being restrained and the staff that was doing the restraining, now the underlying tension no longer seems to be there and is no longer grating on the staff's nerves. The patients seem more relaxed, and less frustrated. They're not fighting all the time to get their restraints off. They seem more independent and active and more able to maintain their dignity.

The nursing home does not seem like such a prison when you walk through and do not find people strapped down all the time. The atmosphere is more comfortable and pleasant and makes one want to visit more often.

By increasing the resident's mobility, I think it makes them stronger and other potential, secondary complications can be prevented. I realize not all patients are candidates for the restraint-free system, but every situation is individual and needs to be treated that way.

We as family and caregivers feel that Tel Hai has made the right choice in adopting the nonrestraint policy.

Thank you.

[Applause.]

Mr. LEWIS. Thank you both very much.

Jill Blakeslee is director for health services for the Kendal Corporation. She originally joined our staff in 1973 as director of nursing. She came to Kendal with 13 years of experience in long-term care and nursing supervision in Delaware, Pennsylvania, and New York States. Jill is the person largely responsible for implementing a no-restraints policy at Kendal, Crosslands, and our other projects.

She has written on this topic and made presentations for numerous groups, including the American Associations of Homes for the Aging, the National Citizens' Coalition for Nursing Home Reform, the National Health Lawyers' Association, and a variety of other long-term care organizations. Her article, "Untie the Elderly," published in the American Journal of Nursing in June 1988, stimulated a nationwide awareness of this human rights concern.

Jill Blakeslee.

STATEMENT OF JILL BLAKESLEE, KENDAL CORP.

Ms. BLAKESLEE. This is quite a morning.

I must tell you that even through I find myself standing here in a state of extreme anxiety before this eminent audience this morning, it is probably the most gratifying experience I have had in my entire nursing career. It is the culmination of many years of constant effort to prove that safe and reliable care can be given to our frail, old people without tying them to their beds and their chairs.

I must say that this effort would have been entirely futile if it had not been supported and encouraged by the board and the administration and the wonderful staff and residents at Kendal and Crosslands. I must take this opportunity to thank them sincerely for their help and encouragement.

Our purpose for this symposium this morning is not to make accusations of poor care. There are many fine facilities across our country who are working very hard to meet and exceed the accepted and mandated standards of practice. But standards and practice change over time in our profession and in any profession, and today we hope to enlist your help in effecting the change to restraint-free care for the very special people who live in the nursing homes across the country.

During my 30 years in long-term care, I have encountered many situations and practices that I didn't like. Some I have been able to change. Some I have had to accept as the requisites of congregate living. But the one thing I could never accept is the fact that the frail, old people in the nursing homes of the United States are routinely tied to their beds and their chairs and they are left to struggle and complain and plead to be free, to spend their entire day concentrating on nothing but getting loose.

While they are doing this, they are becoming emotionally and physically more frail each day that they must endure these indignities.

I am going to take a few minutes to show you what physical restraints are. I know that many of you in the audience today are very familiar with what they are, but I feel that some of you may only have a general idea. A few of you may not know at all.

So if we could just lower the lights a bit so the slides could be seen—who does that here?

I think it is important that before the day moves on we want to be sure that everybody here is familiar with what is being used in the nursing homes across our country.

This is one of the most commonly used type of restraints, the lap belt. I must point out that all of these people here are healthy and happy looking and seem very content to have these devices, but that is not what we see generally.

The Posey vest is another very common device used to fasten people into their beds or into their chairs. They are tied around behind the chair, often in great, long knots that take 3 or 4 minutes just to untie the knots to get them loose.

This, believe it or not, is called the Houdini. How anybody would get out of that I don't know, but I understand they do. They often get hurt in the process.

This is referred to as the crotch restraint. This device is used to keep people from sliding out of their wheelchairs. As you can see, if this person slides forward that device is going to become tighter and tighter and tighter, and I can't imagine that there is any level of comfort in an apparatus such as this.

The Posey vest is often used in beds.

The wrist restraints are most commonly used for people who have nasal-gastric tubes and are fed through the nose or directly into the stomach.

This is the wheel chair with the roll bar and the harness that is sometimes attached to that to keep people from slipping down in their chairs.

This is the infamous gerichair with the tray across. It keeps people in the chair and not able to get up and move about.

Why do we use these devices? The reason most often given is that we want to protect people from falling or eloping from the facility. The fact is that they are often introduced at a time of extreme emotional distress for the resident. She doesn't understand why she is attached to her bed or chair and she becomes increasingly more anxious as she manipulates these ties and she calls out for help, and anxiety often becomes terror and anger.

The caregivers see this behavior and they are convinced that restraint is necessary for her own safety. When the protest doesn't result in freedom, the fighting often subsides and resignation and withdrawal set in.

The resident detaches herself intellectually and emotionally and moves to a level of existence that we have little hope of reaching. This is typical of what we see in our nursing homes today. Restraints have saved her from physical injury, but have destroyed her emotionally for her protection.

Can nursing homes continue these indignities under the guise of protection and safety? We have little official data to prove or disprove that restraints prevent injury, but we do know that restraints cause gross physical deterioration. The physical inactivity resulting from being tied to a bed or a chair causes minerals to drain from their bones, muscles to become weak and nonfunctioning, bladders to overflow and become sluggish and infected, appetites to decline, intestinal activity to slow and constipation to become chronic, and bed sores to propagate.

Combine these with the emotional problems we have previously mentioned, and we have to ask outselves what price safety.

As has been said before this morning, from the inception of Kendal and Crosslands 16 years ago we have had a policy of not using physical restraints. In addition, sedatives, tranquilizers, and other pacifying drugs are used minimally as therapy, not for restraint. When they are used, they are monitored closely and always modified as necessary and stopped as quickly as possible.

We have faced challenges and problems through the years, but we have worked with the residents and we have worked with their families, and we have found that most situations have resolved themselves within a few weeks, at the most. Visitors note the differences when they come to our facilities.

The reaction we have heard most during our years of speaking out against the use of restraints is that what you do is wonderful. That's great work that you do, but we can't do it. We don't have enough staff.

Let's take a look at some of the issues around staffing. The physical and emotional deterioration caused by restraints leads to complete dependence on the caregiver. This is called total care, and it requires the highest number of hours per patient per day.

We are mandated to provide an average of 2.5 hours per patient per day minimum. I will show you it is not possible to care for restrained residents at 2.5 hours per patient per day.

If you use restraints, you are required to remove them at least 10 minutes out of every 2 hours during the normal waking hours to allow the patient to move and to exercise. For example, if we consider that the waking hours are between 6 a.m. and 10 p.m.—that's 16 hours—and every 2 hours we must release those restraints; during sleeping hours between 10 p.m. and 6 a.m. we must release them at least every 4, we can conservatively estimate that each release takes 20 minutes to toilet, to exercise, to change the resident if they are incontinent, and to give skin care and so forth.

So during the waking hours we are required to make eight releases at 20 minutes each. That's a total of 2 hours and 40 minutes.

During sleeping hours, two releases at 20 minutes each is another 40 minutes. So we now have a total of 3.33 hours per patient per day just to release restraints.

Add to this at least 15 minutes for each of three meals, which is 45 minutes, and at least 30 minutes for bathing, dressing, and so forth, that's another 1.25 hours per patient per day for feeding and grooming, and that is a total of 4.5 hours per patient per day for every restrained resident. I'm willing to say there is not a facility in the country that staffs at 4.5 hours per patient per day.

So these numbers explain that we are not able to care for our restrained residents as we have been mandated by regulation for the past number of years.

In addition to that, restrained residents are depressed. They are physically frail, and they are not very interesting to care for, frankly. But they do require much physical effort from the caregiver. The caregiver in a minimally staffed facility is frequently overburdened, resulting in constant staff turnover, and we'll never have enough caregivers.

We at Kendal and Crosslands have been working with several facilities to help them to eliminate restraints. My colleague, Beryl Goldman, will be talking about that in more detail in one of the panels later.

But just for now I would like to say that the staffing at those facilities runs from 2.5 to 3.5 hours per patient per day. Most of these facilities have reduced restraint usage substantially, and none of them have increased staffs because they eliminated restraints. So I think it is important to emphasize this morning that Kendal and Crosslands are no longer the sole providers of restraint-free care.

Since 1986 when we first went public with our Kendal-Crosslands experience, we have been contacted by providers in 37 States. We are aware of facilities in eight States and three Canadian provinces right now that are restraint-free or almost restraint-free. So, you see, this statement that we can do it and you can't is no longer valid.

As I have shown you, the use of restraints requires at least as many care hours as a restraint-free care system if the present regulations are followed when restraints are used. However, I must say that adequate care of the frail elderly with or without restraints will only be accomplished when we are able to offer reasonable daily assignments to the caregiver. The present system of 2.5 hours per patient per day requires the nursing assistant to carry an assignment daily of at least 8 to 10 mostly total-care patients during waking hours and many, many more during the night.

We overburden the primary caregiver. We pay them minimally. And then we lament the fact that we can't attract nor retain good, caring people with adequate skills.

We can continue to regulate the industry forever and ever, but until we recognize the fact that caring for our frail elderly takes more time and attention then we have been able to allow our nursing assistants to provide we will have little hope of meeting the intent of these regulations.

However, the use of restraints does not relieve the burden of the caregiver. Restraints make residents more frail and, in the long run, demand more hours of care.

Often the situation that ultimately brings the family to the decision to give up caring for a loved one at home is their persistent wandering—and particularly at night. After much soul searching they finally have to admit them to a nursing home where they are sedated and restrained.

It costs $2,000 a month or more to live in a nursing home today. If sedation and restraint is the answer to wandering, this kind of care can be given at home.

When asked why he ordered restraints for a confused resident who was strangled in a nursing home, a journalist quoted the doctor who wrote the order, and this is the quote, as published: "The middle of the night is a time for sleep. It is not a time for wandering the hall. They had two choices: to sedate or restrain her. We need to train people, especially those who are confused, that that's not the way things work. You can't give individual care."

Ladies and gentlemen, nursing homes have an obligation to give and provide individualized care.

The frail old people of our Nation are committed to our care because we are expected to have the expertise the family can no longer provide—care for which they often expend all of their financial resources to receive. It takes no special skills to sedate and restrain.

I'd like you to take a look at what is happening in your nursing homes wherever you are in this country. Look at the residents who are restrained. Think about yourselves as you grow old. Is that what you would want?

The elimination of physical restraints is the single most important factor that can improve the quality of care in nursing facilities across the Nation. The dehumanizing effect that restraints have on both the caregiver and the resident has a profound impact on the total caring process. Staff become complacent about using them, believe that they are necessary to manage patients, and, consequently, use them as a means of control.

A physical restraint is in direct conflict to autonomy, and its use undermines the ability of the caregiver to perceive and interact with the older person as an individual.

The new OBRA regulations state, "The resident has the right to be free from any physical restraints imposed or psychoactive drug administered for purposes of discipline or convenience and not required to treat the resident's medical symptoms."

So, you see, the day is approaching when the use of restraints rather than the absence of restraints will bring the facility and its caregivers in jeopardy. So we must start now to untie the elderly.

I thank you for your kind attention. And I sincerely hope you have a very productive day.

Mr. Lewis. Thank you very much, Jill.

We're a little ahead of our schedule. We'll take our break now, and I'd like to ask you to be back in 15 minutes. That will give us more time at the end for questions and answers.

[Recess.]

Mr. Lewis. We'll begin.

I'm very pleased to introduce to you Mildred Simmons, the assistant director of the Office of Health Care and Prevention in the Colorado Department of Health. She also recently assumed the position of president of the Association of Health Facility Licensure and Certification Directors.

Mildred Simmons has worked in all aspects of nursing service in hospitals, nursing homes, public health agencies, and schools. Her governmental regulatory experience began 15 years ago in California with the Department of Health as a nurse surveyor and then led to becoming deputy director of the Department of Health and various other consultant roles to other States before coming to her present position with the Colorado Department of Health.

Mildred Simmons.

STATEMENT OF MILDRED SIMMONS

Ms. Simmons. Good morning. It is a privilege to be here this morning before this group.

I am here before you in four different roles: that as a spokesman for the Association of Health Facility Licensure and Certification Directors, which is the regulatory group that investigates complaints in nursing homes, provides surveys in nursing home, and, in many small ways, provides consultation to nursing home staff. I'm also here having been a former regulator who did the surveys in facilities and who has worked in facilities when regulators were in the nursing homes; I'm also here in the role of a nurse. I've been a nurse in providing all aspects of nursing care for the last 34 years. And, in my fourth role, I share with former panel members in that I am also the daughter of an Alzheimer's patient who is currently in a nursing home in Colorado.

The panel that I am going to introduce to you today brings a diversity of thoughts and belief to today's program on the subject of restraints. However, we have no differences in the belief that all residents are entitled to quality of care affording them a high quality of life, as mandated both in the OBRA requirements and in the long-term care regulations.

We believe that restraint usage should be studied. We should be looking towards the goal of reducing inappropriate uses of devices and chemicals and, when restraining or controlling measures must be used, there should be an ongoing review of their need with a focus toward an alternative means of controlling the residents.

This panel believes there are times when restraining measures must be used and that is unfortunate. The issue, as we will present in this panel, is not the use of a restraint; it is the overuse and the misuse of any of these measures.

To begin our presentation we have a very distinguished lady from the State of Oregon, Joanne Rader, clinical specialist/instructor in mental health nursing, Benedictine Nursing Center, Mount Angel, OR; and the Oregon Health Sciences University. Ms Rader has been the author of numerous publications on wandering and the anxiety of dementia patients.

Ms. Rader.

STATEMENT OF JOANNE RADER

Ms. Rader. Thank you.

I want to share with you today a few thoughts. First, I'd like to share some of the observations that I have made as I have tried to be a part of moving our facility toward a nonrestraint philosophy. The nursing home that I work in is a rural, nonprofit, SNC-ICF facility. For the past 2 or 3 years we have really been working on the larger issue of behavioral management and trying to decrease the use of physical and chemical restraints as part of that process.

I have been really inspired along that path by a number of people that are here in the audience. The first time I heard about dramatic changes in the use of restraints was from Lynne Mitchell-Pedersen in Canada. I have also had the privilege of talking with Neville Strumpf and Lois Evans, Carter Williams, and more recently, with Jill Blakeslee. Building on their work, we have tried as a facility, to move forward in using the least restrictive means of restraint with residents.

One of the things that I have discovered is that the use of restraints is really deeply enmeshed in our health care system. It is not because "bad people" work in or run nursing homes that restraints are used. It is much more complex than that.

If we view the current use of restraints in too limited a light, then our success in decreasing their use will be limited, also. We need to look at the whole picture and how the current use is really enmeshed in our entire social and health care system. The regulatory system, the educational systems, the legal system, as well as some of the societal values that we hold all contribute to the current overuse of physical restraints.

Lois Evans and Neville Strumpf quoted Sister Marilyn Schwab, one of my mentors, who, in the 1970's, served on the Senate Committee on Aging as a consultant. Her statement in a 1975 article in the American Journal of Nursing proposed that the overuse of medications, restraints, and side rails was in part the result of pressure from regulators to prevent falls and wandering away. Many persons and systems have participated in creating the system as we know it today with the overuse of physical restraints.

I think it would be helpful to start by defining restraints because there really isn't consensus about what constitutes a restraint. Jill showed you some pictures of restraints.

Juan de Fuca Hospital in Vancouver, British Columbia, defined restraints as "an externally applied device used to restrict freedom of movement for extended periods of times." They included things like lap belts, Posey jackets, and mitts. Their definition excludes things that they consider to be safety devices such as side rails, bed slings, commode and toilet restraints, seat belts, wheelchair trays, and positioning devices.

The next definition which came out of Kendal's literature defines restraints as "any device used to inhibit a person's free physical movement." It includes things such as the vests, mitts, waist, and then the other things that Jill showed you pictures of earlier.

Things Kendal excludes from their definition of restraints, are seat belts or side rails that are used with the resident's permission or at their request. Tilted chairs were also not considered to be restraints.

California developed regulations several years ago related to restraint use. They made a few distinctions. What I'd like to draw your attention to is another category of devices they called postural support, which they did not consider to be restraints. These were methods used to assist a patient to achieve proper body alignment and balance, and it included such things as soft ties, seat belts, vests, and spring-released trays.

Again, the intent of these devices was to improve mobility and independent functioning, prevent falling out of bed or chair, and/or positioning. They were not done to restrict movement, although they were the same devices that could be used inappropriately under their regulation to control or limit movement.

The next definition is from the Benedictine Center, the facility within which I work. When we were trying to do a study on our current restraint use we used the following definition of restraints: "any mechanical device or equipment attached to or adjacent to the resident's body that they can't easily remove which restricts freedom of movement." It included things such as vest, waist, pelvic restraint, seat belts, side rails, over-bed tables, gerichairs, and a wheelchair brake that was applied in a person who was not able to figure out how to undo the brakes themselves. It also included the hand, the mitt, and the wrist restraints.

That is a very broad definition of restraints, and it is really focusing more on the device rather than the intent of the device. Again, that was for research purposes. I think there is a difference between a clinical definition of a restraint and a research definition of a restraint.

The last definition I wanted to share with you is the OBRA (Omnibus Budget Reconciliation Act) definition of restraint, which is "any manual method or physical or mechanical device, material, or equipment attached or adjacent to a resident's body that the individual cannot easily remove which restricts freedom of movement or normal access to one's body." It includes such things as leg, arm, mitt, soft ties, vests, wheelchairs, safety bars, and gerichairs. It excludes pillows, pads, and removable lap trays.

These are the formal definitions of restraints that I have encountered.

Some of the elements used when defining restraints are: First, a form of physical appliance, second, attached or adjacent to the individual, third, the intent of use (for safety or positioning versus restriction of movement), fourth, amount of time appliance is used (temporary or for extended periods), and fifth, residents or families wishes related to use.

I believe there is yet no clear consensus about what a restraint is and under what conditions certain devices become a form of restraint. That complicates the task a little bit, although it doesn't change the harsh realities that exist.

Informally, one of the things observed by caregivers is that in some views and in some States secured units designed for persons with dementia have been defined as a form of restraint. Facilities have been cited for placing residents in special secured units without going through a formal commitment process.

Some surveyors have looked at recliners as being a form of restraint. A black grid on the floor that was to prevent people from walking over it and going out the door was also defined—again, through a survey process—as being a form of a restraint.

So I think one of the things that we are up against is an inconsistent clinical definition about what is a restraint and what is not.

Lynne-Mitchell-Pedersen's work identified common reasons restraints are used. She identified four categories of behaviors likely to result in the use of restraints: There are people that (1) are unsafely mobile; (2) with disruptive or aggressive behavior; (3) interfere with life support; (4) are wandering. I've added another one to that list, those that need postural support and positioning, because in my definition of restraint I include postural supports as a form of restraint.

Basically, when you're dealing with so many different reasons for restraining people you have to individualize the care to arrive at a solution and that can be complicated.

We have been able to decrease our use of both physical and chemical restraints dramatically in the last 2 to 3 years. Different types of problems require different levels of solutions. For some residents its been quite simple to get them restraint free. Others required additional resources. It has been an incremental process.

One of the things I have observed is that perhaps 50 to 60 percent of the people that are currently in restraints could be restraint free simply by introducing the concept of non-restraint to the family, to the residents, to the staff, to the boards of the facilities; by giving the staff and the family permission to decrease the use; by relieving the fears of being to blame for falls or injuries; and through education on the issues of safety versus freedom and the ethical dilemmas that are involved. These are fairly simple, basic strategies.

The next level is more intensive in terms of resources. This requires probably more education of the staff in the areas of problem identification and individualized care. It also requires additional equipment, consultation, and staff time. I believe that about 30 to 40 percent of the people can become restraint free when we provide this level support.

The most complex level includes approximately 5 to 10 percent of those currently in restraints. I can't figure out how to get this group completely restraint free without tremendous risk to their safety and well being. I use the broadest definition of the term here which includes postural support.

I think it will help for us all to look at decreasing the use of restraints as an incremental process that requires different resources depending upon the types of residents you are getting restraint free.

I think I'm out of time, but let me just share one more thought. There is tremendous excitement out there in facilities toward developing and implementing a nonrestraint philosphy. It is no fun to be the one that has to tie someone down when they don't want to be tied down. I can tell you that from experience.

We need to really provide the permission, support and education to the staff as we work toward these goals. We have to look at the donut and not the hole. If we focus on who isn't restraint free when there has been a dramatic change in getting 50 percent restraint free, then we're going to demoralize the staff. I think we have to be aware that it takes knowledge, skill, experience and time to change the force that created the current overuse of restraints.

Let me share one example with you. A facility told me of an 85 year old woman who liked to carry a babydoll as she paced the floor. She had a circulatory problem that resulted and stasis ulcers on her legs.

She needed to get off her feet more to heal those ulcers. The nursing staff couldn't bear the thought of restraining her, and so they got their heads together to come up with an alternative approach. This is what they did.

The took her doll. They took the head off her doll. They filled her doll with 7 pounds of bird seed. They put the head back on. They gave her the doll. Now when she was walking with the doll she had a very heavy baby. They'd say, "That doll is so heavy. Why don't you sit down and I'll put your feet up." That's how they were able to heal her leg ulcers without using a form of physical restraint. That is a heck of a lot more fun than tying a person down.

Thank you very much.

Ms. SIMMONS. The worst part about being a panel moderator is that one must also be a time keeper.

Our second panelist brings the views of a facility administrator. Fred Watson is the administrator of Christian City Convalescent Hospital in Atlanta, GA. Mr. Watson will provide his perspective on the use of restraints.

STATEMENT OF FRED WATSON

Mr. WATSON. Mildred said we only have 5 minutes, and I talk much slower than she does. [Laughter.]

I appreciate the opportunity to be here today.

I'm also a member of the American Health Care Association. We represent over 10,000 members. Our association supports the Omnibus Reconciliation Act of 1987. We also support the new regulations and the new interpretive guidelines, and we do feel that the reduction of unnecessary restraints and misuse of restraints will certainly result in better quality of care and better quality of life.

Our culture and our society just really hasn't been willing to deal with this matter. We've been using restraints for over 40 years now. We don't know if there is a better way. We think there is a better way, but we've got to find out.

I believe when our Nation sees that there are better options available and the American public demands that something else be done and we are willing to pay for the resources necessary to do this, I think we will see the changes that we all want to see.

Administrators and nurses right now are really caught in a vise between the consumer, the regulatory pressures from the surveyors, on the one hand, and the insurance companies and families, on the other hand.

Regardless of what we hear today, there still are attorneys out there and there still are families that are wanting and willing to sue if a home doesn't use protective devices to protect the safety of the residents. We've got to get over that hurdle.

I had a family just recently where their mother fell. It was an accident. The family came to me and said, "Okay, she's fallen once, but if she falls again I'm going to sue you." So that's the pressure that the administrator and nurses are under, and we have to deal with those kind of pressures.

Our facility opened 12 years ago, and we were restraint-free for about a year and a half. Now we are not. We have about 20 to 30 percent of our residents that are currently restrained, many of which do want to be restrained and have requested that the restraints be applied.

We have discussed numerous times with the residents' counsel and the family counsel in our facilities. The residents and the families tell us—some of them—they want to use the safety belts and the devices. They don't want them removed.

We've got two problems. The primary reason we use safety devices is to protect the safety of the residents. We feel like we give good care. We only have one decubitus in our entire facility. We do try to follow the regulations of the proper release. I'm not going to dispute the statistics presented earlier, but I think there needs to be more study on the staff time it takes to manage residents in restraints and those that are not in restraints.

Also, the residents say, "I want that person restrained because I don't want them coming into my room and taking things off of my nightstand." So we do have a problem with wandering residents within the facility and the protection of the rights of the other residents.

We recently had six nurses visit us from Manchester, England. The purpose of having them come over to our facility was to explore the restraint-free environment that they have. They summed up the differences in their country and ours in two words "culture" and "litigation."

Over there they accept the fact that residents will fall. They know residents are going to fall. There is no litigation there. These nurses served in three different facilities in Manchester, England. None of them have private rooms and semi-private rooms. They are all open-type wards and the nurses are able to observe the residents for potential falls much better than they do in the semi-private and the private accommodations that we have in this country.

With the new regulations that were passed and will be implemented in October 1990 I believe we are going to see a big change. We support those regulations and we're not going to have business as usual. I believe if we give those regulations a chance to work and through the new assessment process and the care planning process we're going to see a dramatic change in the use of restraints in this country.

There are over 16,000 homes in the country. We have been told this morning there only about a dozen that are restraint-free, so we've got a long way to go. There are a lot of homes already—probably 1,500 to 2,000—that have a very minimal use of restraints. So there are some homes that are doing a good job.

We need to continue to work to reduce restraints in this country, to take the legal issue of whether to use restraints or not out of the courts—and if you have to go to court do it on whether a facility gives good care or not, not whether it uses a restraint or not.

I need to talk just a moment about the resources and funding. Most facilities across the country are faced with the lack of adequate personnel to work in long-term care. Many States only reimburse, as we have heard, for about 2 hours or 2½ hours of care per resident per day in a nursing home. This is very inadequate, and I must admit it contributes to whether or not a facility uses restraints. If a facility has 50 residents on a wing or a floor and at mealtime 25 of those residents have to be fed by the staff, and you've got 2 or 5 or 10 other residents that are wandering, it is impossible with three or four personnel to manage all of them. So we do need to study that issue more.

We need at least 4 hours to care for a restraint-free environment. I'm not sure our State of Georgia is willing to pay or can pay for that kind of staffing at this time.

Our reimbursement rate is an average of $40 per day. You can't get an inexpensive motel for $40 a day. That's what we are up against.

Just to add 1 hour of additional care per patient per day would cost the taxpayers half a billion dollars a year, so it is going to cost us more money, I believe, to be in a restraint-free environment.

Some States actually have case mix reimbursement systems that actually pay more for a facility to use restraints on the assumption that persons in restraints requires more staff time, so we've got to deal with that conflict. It is actually an incentive in some States to use restraints.

I feel that we do need more studies, more information, and more data. Whether we do it through Health Care Financing Administration or whether we do it with an independent study, let's get a real handle on this. Let's find out what the insurance companies feel. Let's see what the litigation factors are going to be. Let's see what impact it is going to have on the staffing.

I think we can achieve the goal which we are trying to accomplish here today.

Thank you.

Ms. SIMMONS. To bring another perspective to this issue, it is my pleasure to present Arnold Silverman, representing the manufacturer of restraining devices. Mr. Silverman is the president of Skil-Care Corporation of Yonkers, NY.

Mr. Silverman.

STATEMENT OF ARNOLD SILVERMAN

Mr. SILVERMAN. Thank you.

As Mildred noted, I represent Skil-Care, a company that manufactures a broad range of patient safety and comfort products, among them restraints.

In regard to the use or nonuse of restraints, I'd like to concentrate my remarks in three areas—responsibility, input, and options. These, by the way, form the very attractive acronym of RIO, which, quite honestly, is where I'd rather be right now. [Laughter.]

It sure beats being a restraint manufacturer at an "Untie the Elderly" symposium. [Laughter.]

But anyway, responsibility for patient safety, comfort, health, and dignity is shared among caregivers, providers, advocates of restraint-free facilities, lawmakers, and manufacturers. All of us have a responsibility.

Facilities and the professionals who run them have the responsibility—medically, ethically, legally—to follow the very reasonable and human requirements set forth by the Health Care Finance Administration which states, "The resident has the right to be free of physical restraints imposed for the purposes of discipline or convenience and not required to treat the patient's medical symptoms."

While limiting the likelihood of their abuse, this rule also acknowledges that there perhaps are conditions under which these devices may be necessary. Caregivers, therefore, have the responsibility to examine all alternatives to restraints and to use their professional judgments to make informed decisions as to when and in which specific cases these alternatives may be used.

Advocates of restraint-free facilities have a responsibility. Their responsibility is to provide caregivers with concrete, realistic alternatives that these caregivers can consider, evaluate, test, and compare. Providing broad nonspecific answers to important questions about patient safety is perhaps an evasion of responsibility. Telling providers—as Untie the Elderly did in their August, 1989, newsletter—that alternatives must be tried until something works is, to my mind, a risky and perhaps unsatisfactory suggestion.

We manufacturers have responsibilities, too. We have a lot of them. Among them is the need to monitor the ways in which our restraints are applied. One of the most frequently used devices is the cross-over vest. I have a picture of it.

It was determined that many restraint-related incidents were the result of this vest being applied backwards, which you can see in the lower corner there, with the opening to the patient's back and the neckline up near the patient's throat. This was dangerous.

Therefore, as a part of our instructions and our educational materials, we very strongly emphasized that this method, which is very commonly used in nursing homes, is not the way to do it. This illustration, by the way, is from our in-service video on the use of restraints.

We are confident that making caregivers aware of this and perhaps other problems will substantially reduce restraint-related incidents.

In line with that, we manufacturers have the responsibility to provide in-service material to make certain that those who select and apply devices do so correctly. We have a competence-based in-service program that not only includes a videotape demonstration of how to use restraints, but there is also an in-service manual. This manual has within it testing procedures that determine or that help the in-service director to determine competence before that device or those devices are used on the wards.

Manufacturers further have the responsibility to listen to health care professionals and to work with them to design alternatives to certain kinds of restraints. In a few minutes I am going to show you some of those alternatives.

Lawmakers have the responsibility of drafting and enacting the laws that will form the basis of the ways in which we care for our elderly. To discharge that responsibility it is vital that all informed points of view are solicited and considered before any decisions are made and any policies formulated that would affect the broad range of options from which nursing care professionals may choose in determining the best and safest ways to care for their patients.

Failure to establish a consensus on the issue of restraints may lead to policies that could, indeed, threaten the safety of aged patients. Lawmakers—indeed, all of us—need more information about restraints. We need input.

A comprehensive review of the literature dealing with restraints appeared in the January 1989, Journal of the American Geriatric Society. Its authors state, "Since 1980, the literature regarding restraint use with the elderly has increased markedly. Actual research on physical restraint is, however, sparse."

Untie the Elderly echoes this. In the small group notes from their August 9, 1989, planning meeting they state, "Very little research has been done on the issue of restraints up until this point." Indeed, they go on to define these areas as areas in which we need research: impact on patients. Are there some individuals who need them? Are there some conditions that warrant their use?

This call for research and input is well taken. Doctor John Blass, by the way, chairman of the President's Committee on Alzheimer's Disease, has specifically stated that there is a great need for funding for research in the use of restraints.

This research, this input, should come from facilities with diverse patient populations and staffing conditions, from risk managers, nurses, doctors, manufacturers, and from patients and families, too.

From input we develop options. I want to speak specifically about some options that we offer.

Our company takes a minimalist position on the use of patient safety aids. We believe in using the least restrictive devices possible to meet a patient safety need. For example, sliding out of wheelchairs is a problem that one encounters among a good number of nursing home residents. I have a slide here.

For some patients, a wedge-shaped cushion like this is sufficient to prevent forward sliding; however, if this doesn't work we may want to try this next device, which is a pommel cushion. It is a gel cushion. A patient sits on this comfortably, and that foam protrusion keeps them from going forward.

If this doesn't work, a patient may require an even more secure slider belt. This belt, by the way, was developed by a facility and recommended to us.

Many patients—most patients, indeed—require no more than a simple wheelchair belt. For those who can get up and walk around unassisted we have this easy-open, velcro-type belt. Patients can open it up and get up and walk around, but when they're seated they can have a sense of safety. So here we are combining safety with autonomy.

Other patients, who should not walk about unassisted, may find this belt an invitation to injury. That's why we also offer this polyfoam padded belt that ties behind the wheelchair out of the patient's reach.

The caregiver should have the option of selecting the appropriate belt based on his or her personal knowledge of the patient's capabilities or limitations. Now, this is not an option I think we should eliminate.

I want to conclude my remarks by again quoting from the article in the Journal of the American Geriatric Society—and Linda Evans, one of its authors, is here today. The article says,

> With an increasingly frail aging population, situations where elders appear unsafe, uncooperative, or noncompliant with care will become commonplace. The need, therefore, to balance autonomy, patient safety, and quality of life will be essential. A remaining challenge in meeting this need for patient care is the development and testing of alternative measures to physicial restraint.

This is, indeed, a responsible statement. It calls for input and it does not limit options. We, in the health care products manufacturing industry, accept this as our goal.

I want to thank you for your attention.

Our last presenter will focus on the risk management perspective on the use of restraints. David Mettler is the director of Risk Management, The Hillhaven Corporation, Tacoma, WA.

Mr. Mettler.

STATEMENT OF DAVID METTLER

Mr. METTLER. Thank y ou.

First of all, I'm not a public speaker. I am a risk manager. So please excuse me if I do stumble a little bit and read some of my notes rather than talk directly to you.

When I first was informed of the opportunity to present to this group I went to our legal counsel and discussed the title of the symposium, "Untie the Elderly: Quality Care Without Restraints." We maybe suggested a different title, from the risk management perspective, "Untie the Elderly, Tie up the Attorneys."

That kind of gives you some background as to where I am coming from.

Hillhaven is a large company that operates approximately 345 skilled and intermediate care facilities in about 38 states. We have about 42,000-plus licensed beds. We also operate retail pharmacies and institutional pharmacies and operate several retirement centers. We employ approximately 35,000 people.

The United States, as you all are aware, is a litigious society which looks to the courts to solve many of our problems. It is increasingly true in regards to the elderly. Many people believe that when an injury occurs someone is to blame and should be sued. Other countries, particularly Europeans, see health care as a compact with the government and, therefore, have few, if any, lawsuits involving negligent care.

Liability issues are present for both use and nonuse of restraints. Hillhaven facilities have been sued—sometimes successfully, other times not—for failing to use resident restraints. Improperly applied restraints have also been causes of action.

A facility that for philosophical reasons operates under a restraint-free policy might inherently be committing a negligent act by failing to restrain a resident who required restraints irrespective of what other steps it took to prevent the resident from injuring himself.

In certain circumstances where restraints are considered to be part of the treatment, nonuse may constitute medical malpractice. We have had several allegations to that fact.

Most incidents in which an unrestrained resident was injured do not result in a reported judicial opinion. The fact that some of the jury verdicts against the facilities were reversed on appeal or that the case was settled prior to the trial has little bearing on the evaluation of risk exposures in this area. The company and/or its insurers still have to expend significant sums of money to defend itself. In addition, outside of the litigation, the adverse publicity associated with such incidents and the resultant damage to the facility's reputation are reasons to be concerned with restraint policies and procedures.

I pose a question. If restraints were totally eliminated, will the facility be relieved of any responsibility for resultant injuries alleged to have been caused by lack of restraints? Will there be immunity from liability? I suggest probably not.

Another issue is employee safety. Most nursing home injuries to employees in our facilities occur during transfer or handling of residents. With less use of restraints there may be an increase in the number of incidents of employee injuries due to staff trying to prevent resident falls. We need to further study this area.

We generally support the movement to less use of restraints. We support the Health Care Financing Administration's interpretive guidelines that state that the resident has a right to be free from any restraints administered for the purposes of discipline or convenience and not required to treat the resident's medical symptoms. Our facilities use restraints only when appropriate and pursuant to physician orders.

We believe that the use of restraints should be assessed considering the evaluation of each resident's mental and physical abilities by the treating physician in conjunction with the desires of the resident and the resident's family. The safety and well-being of the residents should always be a determining factor.

Sometimes it may even be necessary to restrict the rights of an individual resident in order to provide for the health and safety of others. For example, an abusive or an aggressive resident whose activity is not restricted in some way may pose a risk of harm to other patients and staff.

We are concerned about any potential or existing legislation that mandates total elimination of restraints without regard to other factors such as, one, physician orders for the safety of the resident; two, resident and/or family desires; three, training with related expenses necessary to achieve a reduction or elimination of restraint usage; four, inadequate reimbursement levels for existing costs, let alone increased costs associated with such legislation.

Risks inherent in not restraining a resident whose medical condition indicates that the use of restraints is a prudent course of action are significant. The courts continue to impose liability in situations where none previously existed. Making the transition to a completely restraint-free environment is difficult.

Hillhaven has undertaken several pilot projects at our facilities to evaluate the implications of using fewer restraints and exploring alternative behavior modification in appropriate residents. So far results have been very encouraging.

In summary, while we all can agree that overuse or wholesale use of restraints is not desirable, it is equally wrong to say no restraints should ever be used. Since a number of court cases have held that the use of restraints may constitute medical care and treatment, the government should not be precribing medicine. Only licensed health care practitioners can treat patients and ensure the dignity and safety of all residents.

In closing, this is not a black and white issue. That restraints are not good or are always good or always bad is not the question. Their use must depend on the specific needs of each resident. Because each resident is different, the treatment of each resident must be based on his or her own problems and needs. The physician, family, and other caregivers must be able to explore all options for care in treating each resident.

We recommend that any program aimed at reducing or eliminating restraints be undertaken in a careful, slow, cautious manner to fully assess the abilities of each resident and to adequately educate residents' families, treating physicians, and staff in properly caring for residents in a new environment.

Thank you.

Ms. SIMMONS. You've been privileged to hear from four very articulate individuals who have expressed their beliefs, their concerns, and alternative points of view to a 100 percent restraint-free environment. Their views are, I'm sure, shared by many in this room and in the long-term care community.

This is not the naysayer panel; but, rather, the group that says more work must be done in this area for a restraint-proper, not a restraint-free, environment can exist.

We believe the issue of restraint or control and patient rights must be studied.

As the spokesperson for the regulatory profession, I'm hopeful that the issue of moving into a restraint-free or restraint-proper environment will proceed slowly and cautiously to assure that residents are protected and families are assured that proper care is provided by those to whom they have entrusted their most valued possession—a mother, a father, a wife, or other.

States must be ready and willing to increase existing staffing ratios. In my own State of Colorado, the mandated staffing ratio is 2 hours per patient day—clearly not at a level to go into this new concept.

This panel would like to offer the following recommendations to the Senate Special Committee on Aging.

One, the convening of a special committee composed of representatives of consumers, providers, family members, regulators—both State and Federal—manufacturers, insurers, legal experts, advocates, and the public, geographically selected, to discuss the use of devices and chemicals and to provide a report to this committee including recommendations specific to the potential for a restraint-free environment. This must include a report on the additional costs to the Medicare and Medicaid programs.

Our second recommendation is the establishment of several pilot projects to study this issue involving different patient payment sources, differing payment populations, and from both large and small States in several areas of our country.

We would also like to see the establishment of a centralized clearinghouse for information on the subject of restraints, including alternatives to any devices and chemicals.

Our fourth recommendation is increased information and training to consumers, to families, and to the public about the use and misuse of restraints.

The current training requirements under Medicare and Medicaid only apply to facility staff. We believe that families must also be alerted to the misuse of restraints and that there are, indeed, alternatives.

Finally, an in-depth study including Medicare and Medicaid funding in all States to determine the total cost of a restraint-free environment.

The focus of HCFA currently is to encourage States to establish a case mix reimbursement system—which, incidentally, as you heard, provides an incentive to those facilities who have patients in restraints. We believe that the incentive should be redirected toward the use of alternatives in the use of restraints.

Finally, would we hope that the move toward a restraint-proper environment allows for an appropriate, well-monitored use of devices and chemicals when medically needed, as defined in an accurate resident assessment.

On behalf of the panel I would like to thank you for your attention. If we can provide any further information, we will be here all day.

Thank you.

Mr. LEWIS. We now have two speakers to address the legal issues involved in the use of restraints. Alan R. Hunt, Esq., of Montgomery, McCracken, Walker & Rhoads, Philadelphia, is vice chair of the firm's Health, Education, and Nonprofit Department. A graduate of the University of Michigan Law School with an advanced degree from Harvard Law School, he has over 30 years' experience in health care and nonprofit corporation law, as well as trust, estates, and fiduciary administration. Mr. Hunt speaks frequently on health care and nonprofit issues and has authored a number of articles and monographs on aspects of health care.

He also serves as chairman of the board of the Kendal Corporation. He has made numerous presentations on the legal ramifications of restraint elimination.

Alan Hunt.

STATEMENT OF ALAN R. HUNT, ESQ.

Mr. HUNT. Thank you, Lloyd.

I've done a paper, which I understand will be available to you before the day ends, in which I have gone quite deeply into the cases—everything we can find out from the cases about the legal liabilities resulting from failure to restrain or from misuse of restraints.*

I don't think it is useful to stand here and run through all those cases with you. I do hope that this paper, which I would regard as in the nature of a brief, will be something that will be useful, at least to some of you, to take with you, to talk with others about, to show to others, and try to bring this nagging question of legal liability out into the open and expose it for what it is.

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*See appendix 2, p. 197.

I do want to just let you have the conclusion of this paper, which I put at the beginning.

> Health care institutions may abandon the use of physical restraints without incurring a significant risk of being sued for malpractice. There are few precedents supporting successful malpractice claims against long-term care facilities based upon a failure to restrain.
>
> In fact, the striking conclusion from an examination of cases involving restraints both in nursing homes and in hospitals is that the use of restraints has produced more successful lawsuits than nonuse.

[Applause.]

> Moreover, the strong trend of Federal regulations to limit use of restraints makes it even less likely that a failure to restrain will be held actionable in the future.

You have heard the text of those new regulations, and I'm told that, as a practical matter, they are already, in many cases, being observed.

Now, you can argue, I think, and quibble around the edges a little, but I don't think any fair-minded lawyer looking at the cases, looking at what courts have written and what courts have decided, could quarrel with the conclusion that I have just given to you.

We are, indeed, litigious. If we are so litigious, why are there so few cases upholding liability for failure to restrain?

The sad fact is that probably the reason is the limited economic worth of injuries to or death of a frail, elderly person. If you want to put the worst face on it for the attorneys, there isn't that much incentive.

I can accept the fact that there is often familial resentment or grief or anger, but just as an economic proposition, bringing lawsuits growing out of injuries to frail, elderly people is not a very promising business.

We are now, with these new regulations, entering a brand new legal environment. I would suggest to you that if there was very little evidence of liability before growing out of failure to restrain, with the new regulations I really don't see these cases being brought or brought successfully at all. By the way, I would agree with the representative of the insurance company that lawsuits are to be avoided, not to be won. The important thing is not to get in a lawsuit. I appreciate all the negative aspects of that, and nothing I say should be regarded as taking away from that.

If there is any remaining doubt, let me just give you a couple of real horribles.

There is an Alabama case which is current right now—we monitor it on a weekly basis to try to find out the latest developments—in which $2.5 million in damages was awarded for the accidental strangulation of an 86-year-old woman. An incorrect size vest was used, the staffing was inadequate, and the staff was not trained in the use of the restraint.

Now, that amount of money sounds pretty inconsistent with what I just said about the limited economic value of frail, elderly persons, and, indeed, that's true. I think clearly this was a punitive award, and an effort is being made right now to set aside or to knock down the amount of the award. That hearing was supposed to be in October. We haven't been able to find out just exactly what has happened. I do think an award like that is plainly excessive unless there were just extraordinary circumstances that don't appear in what has been available to us.

There is a criminal case which has arisen in Denver. We have been in touch with the District Attorney's office out there. The preliminary hearing is scheduled for January. This involved the death of a schizophrenic, elderly, blind woman. A Posey vest was put on backwards. The patient's door was closed—against the regulations of the nursing home. The patient strangled. The probable charge here will be negligent homicide. So there is a criminal aspect here, as well.

In giving the cases and the results of cases around the country, it has been brought to my attention that this isn't, by any means, all of the picture. The real picture and real reality is in countless decisions and conversations and dialogs between nursing homes and their insurance carriers, and that's where it is really at. I accept that. I think we have a lot of work to do in that area.

I talked with the safety engineer of a major insurance carrier in Philadelphia and I asked him what their view was about restraints, how they approached restraints. He said very carefully. He said they are probably—the balance is swinging—they are probably more concerned now with the misuse or inappropriate use of restraints than they are with the failure to restrain. They are very, very interested in going around and examining practices and talking with people about what they do, with whether the use of restraints has been adequately documented and adequately supported by prescription, and the like.

They have, by no means, a blanket bias in favor of the use of restraints. If anything, I would say their bias has now shifted the other way.

I tell you this. It is not a national study. Plainly, it is one company, one experience. I think we need to know a lot more about the attitudes of carriers and spend a lot more time in this area talking with them and trying to make clear to them that they are operating now, since the new regulations, in a totally different legal environment.

What I think we have now is really kind of a dinosaur problem. We've got this old mythology out there about legal liability that a lot of people continue to believe, and yet the cases are to the contrary. What do we do about that? I hope it will be helpful to give you the kind of legal material that I have put together and that Marshall has, as well.

I hope we can spend some time surveying and talking with insurance carriers across the country, getting a much deeper, broader feel for this question than we have now. I hope we can spend more time getting the word out to doctors, who certainly have to be concerned and are very much concerned with liability questions. And I hope, finally, that we can get the word out to any boards of directors, administrators, and directors of nurses, who are not really thinking correctly, who have not been correctly informed on these liability issues.

It is at that point, of course, that I turn to you. I hope that you will return home—any of you who did not come with the correct ideas—and spread the good word where you are.

Thank you.

Mr. Lewis. Thank you very much, Alan.

Marshall B. Kapp was educated at Johns Hopkins University, George Washington University, and Harvard University. In addition, he is a licensed nursing home administrator in the District of Columbia.

In his positions with the Health Care Financing Administration and the New York State Office of Federal Affairs he gained substantial experience in health regulation in general, and in aging in particular.

Since August 1980, he has been a faculty member of the School of Medicine at Wright State University in Dayton, OH, and a member of the Steering Committee for the WSU Center on Aging Research, Education, and Service.

Marshall Kapp is widely respected for his writing on the legal aspects of aging and health care.

Marshall Kapp.

STATEMENT OF MARSHALL KAPP

Mr. Kapp. Good morning. It is a pleasure to come to Washington to hear attorneys get beat up upon. [Laughter.]

As the only attorney in a medical school, I'm kind of used to that.

I'm going to try not to repeat too much of what Mr. Hunt said, although there will be some overlap. Hopefully that overlap means that we are right.

At a recent meeting of the Gerontological Society of America, I conducted a poster presentation on the prevalence of legal risk management systems—organized, internal approaches to the identification, prevention, and mitigation of incidents that might lead to potential legal claims—in American nursing homes.

During the course of 90 minutes I was struck by the fact that four separate individuals, totally independent of each other, approached me and asked if, by risk management, I was referring to such practices as physically restraining nursing home residents so that they do not fall down, injure themselves, and bring lawsuits against the facility. This was the image that the people looking at a presentation on risk management had of what risk management is all about.

Apprehension of legal liability is frequently used as a pretext for actions actually based on professional bias, staff convenience, behavior control, and, as we have heard this morning, financial incentives.

Physical restraints have been used historically in this country since long before the litigation explosion of the past quarter century, long before invention of the concept of defensive medicine. Nonetheless, there is little doubt that, to a significant extent, a sincere fear of liability—or at least of litigation—fuels the widespread practice of physically restraining residents of nursing homes in the United States today.

Regrettably, I think, some legal commentators and risk managers unduly exacerbate this anxiety. Attorneys and risk managers can function either as paid paranoids or as enablers. It seems to me that, in addition to addressing all the groups that Mr. Hunt urged that we address, we've also got to educate the attorneys and the risk managers who fuel the paranoia and the anxiety among health care providers.

As has been urged in a recent editorial in The Gerontologist, "The legal noose now thought to be around the necks of the nurse, physician, and nursing home administrator who do not restraint every resident who falls or may fall must be exposed for the myth it is."

In my brief time today I propose to take up this challenge by, first, placing the legal risks associated with nonrestraint of residents into some realistic perspective. I don't think either Mr. Hunt or I are "Pollyanna-ish" about potential exposure of nursing homes and their personnel to legal risks associated with nonrestraints, but what we do want to do is put those risks into some realistic perspective. Second, I will suggest risk management strategies for providers to reduce these risks even further. Finally I will suggest some public policy options for overcoming the legal paranoia that too often dictates the improper and deleterious use of physical restraints in American nursing homes.

I don't know personally if we can achieve a restraint-free long-term care environment, but it seems to me the key issue is where the presumption is going to lie. Are we going to have a long-term care system where we entertain a presumption against restraint and on a case-by-case basis decide, in some cases, that restraints may be needed and where the burden of proof rests with and is met by he or she that would impose the restraint? Or, are we going to have the kind of system that, unfortunately, we largely have today where the presumption is in favor of routine, indiscriminate restraints and it is, indeed, the exception where that presumption is overcome?

First, let us put the legal risks into perspective. Although their number has been relatively small in terms of overall health care malpractice litigation, there indeed have been some lawsuits, which you have heard about today, in which nursing homes and their personnel have been held legally responsible for injuries incurred by nonrestrained residents. This fact does not by any means, however, support the notion that widespread, indiscriminate, routine use of physical restraints is a prudent, effective form of defensive medicine or risk management for providers.

First, lawsuits are not successfully prosecuted against facilities solely for failure to restrain a resident. Prevailing plaintiffs have had to prove, by a preponderance of evidence, other elements of negligence such as improper assessment of the resident, a failure to monitor the restraint appropriately, inadequate documentation concerning resident care, or failure to respond to the fall in a timely and professionally acceptable manner.

Further, as you have heard, legal exposure associated with failure to restrain residents is substantially outweighed by the legal risks attached to the improper application of physical restraints.

Mounting data show that physical restraints used in the name of defensive medicine may not only fail to be defensive, but may actually be counterproductive. Studies demonstrate that the chance of morbid outcomes, including injurious falls, increases with the prolonged use of mechanical restraints. And bad outcomes, especially when they are unexpected by the resident or family, are the most reliable predictor of lawsuit initiation.

Additionally, contrary to prevailing wisdom, the rate of serious injury falls does not increase significantly in the absence of restraints.

In quantitative terms, as you have heard, cases holding providers liable in the absence of nursing home restraints are far eclipsed by legal judgments imposed and settlements made on the basis of inappropriate ordering of restraints, failure to monitor and correct their adverse effects on the resident, or errors in the mechanical application of the restraint. Thus, the rational health care provider, if guided solely by legal self-interest rather than resident welfare, ought to opt more often for withholding rather than imposing restraints.

Even more important, regulatory sanctions—and you've already heard some discussion about regulatory sanctions—such as delicensure and decertification from the Medicare and Medicaid programs, which are a much greater concern for nursing homes than possible tort liability, are substantially more likely for imposing rather than withholding physical restraints. I'm sure you'll hear more about that later today.

Let me say something about risk management through the notion of resident assumption of risk. Even the relatively limited legal risk associated with nonrestraint of residents may be reduced in many situations by shifting it—the legal risk—to the resident or the resident's substitute decisionmaker. In the lawsuits that have been filed in which injury occurred to an unrestrained resident, there is scant evidence that, as a matter of basic informed consent, anyone communicated adequately with the resident or substitute decisionmaker concerning the benefits of proposed restraints, the reasonable alternatives, and the potential adverse consequences of foregoing recommended restraints.

In other health care contexts the courts have recognized the doctrine of assumption of risk as a complete defense to a negligence action where the patient voluntarily and knowingly, i.e., after being adequately informed by the health care provider, refused to comply or cooperate with the provider's recommendation and agreed to accept responsibility for foreseeable adverse consequences of that decision. In the formal remarks which I'm submitting to the committee I will have cases cited to that effect.*

Some courts have alternatively or additionally permitted such a defense by characterizing the patient's conduct as contributory or comparative negligence.

These defenses should be fully applicable to physical restraint situations where the resident or surrogate is informed of the potential risks, understands them, and voluntarily accepts the consequences. We permit individuals to take risks in all other aspects of everyday life, including the medical decisionmaking realm, such as permitting AIDS patients to experiment with medications of unproven safety or efficacy and carrying tremendous potential side effects.

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*See appendix 2, p. 203.

There is no reason to restrict the choice of nursing home residents or those acting in their best interests from knowingly and voluntarily accepting specific, limited risks of injury in exchange for a modicum of freedom and dignity, particularly where alternative strategies and technologies exist to accomplish the same legitimate goals as restraints with much less restriction or intrusion.

In addition, from a psychological perspective, residents and substitute decisionmakers who share in the decisionmaking process are less apt to try to shift the blame to someone else in the event of a mal-occurrence.

Although the mental incapacity of many nursing home residents may make rational conversation and decisionmaking on their part infeasible, the law's formal recognition of the authority of appropriate substitute decisionmakers is growing. Unless the substitute is acting in clear disregard of a resident's best interest or personal values and preferences, the substitute should be able to choose nonrestraint on the resident's behalf, accept the accompanying risks, and thereby relieve the nursing home of potential liability.

It has even been suggested that we experiment with the use of advance directives, analogous to living wills and durable powers of attorney, to allow presently capable individuals to express and document their preferences concerning the use of physical restraints in the future eventuality that they become decisionally incapacitated and placed in a nursing home.

I will now discuss public policy options.

In the context of examining the practices of a State hospital for the mentally retarded, the U.S. Supreme Court observed in a 1982 opinion that, "An institution cannot protect its residents from all danger of violence if it is to permit them to have any freedom of movement."

The same observation holds even more true in the nursing home arena. Several policy options should be considered in an attempt to strike a good balance between the facility's right and duty to protect residents, on one hand, and the residents' freedom, on the other.

First, the States, with Federal encouragement, should unambiguously enunciate the applicability of the assumption of risk doctrine to the nursing home physical restraint context, assuming that risks are understood and accepted by or for the resident in a voluntary, competent, and informed fashion, and that proper documentation is present.

Failure to do this obviously discourages shared decisionmaking. One can hardly expect or require that providers permit residents or their surrogates to make their own decisions, on one hand, and, on the other, hold those providers legally responsible for poor outcomes which result from a choice made by or for the resident.

Unequivocal enunciation of the assumption of risk doctrine carries strong benefits for residents, providers, and society.

Second, courts and legislatures must clearly recognize and enforce standards of medical practice that are based on scientific evidence rather than industry custom or fashion. As previously cited data indicates, this would mean a legal standard favoring nonrestraint rather than the current deference toward industry habit.

Published provider standards and actual behavior could be expected to follow the legal incentives.

Third, since perception of the law is a more important determinant of behavior than is reality—I underscore this point—a large-scale educational campaign—Mr. Hunt has referred to that—is needed to convince providers that a more judicious and discriminating use of physical restraints is sensible, legal prophylaxis as well as good clinical practice and promoting of resident dignity and autonomy. This campaign should include publications, continuing education programs, and joint efforts with trade and professional organizations. Government has a role in financing, sponsoring, and promoting such efforts.

Finally, providers must be convinced that their indiscriminate, inappropriate use of physical restraints places them at much greater relative liability risk than does less reliance on restraints as a first strategy for resident control.

Courts must be sympathetic to plaintiff claims of improper restraint, and legislatures and administrative agencies must continue to limit the permissible circumstances for restraint use and vigorously enforce stringent health and safety requirements regarding their imposition, monitoring, continuations, and documentation.

Let me say in closing that I think ideally all of us, including the nursing home industry, are educable on the issues under discussion at today's hearing.

To the extent, however, that education, persuasion, and voluntary incentives do not work, we should—if we have to resort to command and control sorts of regulations—at least regulate in the direction of a presumption against restraints rather than the current industry custom in favor of restraints.

Thank you.

Mr. LEWIS. Thank you very much, Marshall.

I'd like to ask all of the presenters of this morning if they would join us here so that we could open up the forum to questions and so that anyone who has questions can direct them to anyone that they wish.

We'll have about a half hour for questions. Please begin.

STATEMENT OF MS. IVANCIC

Ms. IVANCIC. I'd like to ask a question of the lawyers, being a lawyer myself, and working on behalf of a nursing home, having to talk to some of these people who have had someone they love be hurt in a nursing home, and having to explain to them that there was no restraint order, the person was walking as they do every day up and down the hall to the dining room, and then they hurt themselves or got hurt by another patient who was not restrained and who may have gotten out of control.

I just take exception to one point that there seems to be a basis of assumption here that no reported cases equals no cases equals no claims by residents or their families. I think that's not the case. I'd like either a little bit more explanation of your idea that there really are no reported cases and that that should indicate that there is less liability for not restraining patients.

Mr. HUNT. I think that was my statement, so let me respond.

We have, I think, two or one and a half reported cases which seem to be pure failure to restrain cases. It is difficult to isolate these things because liability is so often predicated or not predicated on a number of factors. A pure failure to restrain case is really a great rarity.

You are entirely correct, and it has been a great frustration to me all along in saying that what I'm talking about is reported cases and that there is all sorts of stuff out there that is not reported. I have tried very hard to chase down some of the cases, going after news reports and talking to nursing homes. It is often very difficult to get the information about a case that doesn't go beyond the trial level, and trial court decisions are often not reported in this country. I will grant you that I am reading appellate decisions. That's one of the reasons I think we need to go more deeply into this and spend more time with the insurance companies.

Mr. **Kapp**. It seems to me, also, that one has to ask the question of what the realistic litigation exposure is—and, as I said in my presentation, I don't think either of us is Pollyanna-ish about that. There is some litigation and potential liability exposure, but I think one has to ask whether that exposure is so great as to dictate standard practice in the nursing home.

Mr. **Lewis**. I'd like to add a comment of my own and say that I don't think that there is an administrator in the United States who has not been threatened at some time by a member of a family with the possibility of being sued because they didn't do the right thing—whatever that right thing was. That is something which has happened to many of us repeatedly. Of my own experience over the years, hardly 6 months would go by that I wouldn't have some kind of a threat of that nature, and those have to be dealt with.

I'd like to ask the questioners to identify themselves first so that we can have that on the record.

STATEMENT OF JOANNE LYNN

Ms. **Lynn**. I'm Joanne Lynn. I'm a physician at George Washington University.

I had two sorts of comments. One is that the claim that we can handle this as a treatment choice issue on the basis that Marshall has laid out is under some assault from a thoroughly unexpected direction, at least from practitioners and nursing home administrators, and that is that in at least two States right now the court cases have mandated that patients will not die without their electrolytes in balance and their nutrition supported.

As one of the speakers mentioned this morning, the major cause in nursing homes of mitts and wrist restraints is the maintenance of feeding tubes.

So if in Illinois and Missouri right now you may not let a person die without a feeding tube who is incompetent, then at least in those States you cannot go without restraints in those nursing homes unless you're going to somehow magically be able to get G tubes into everyone without having to have the same sorts of consent. I think this is just a way in which an issue fought on other grounds is cycling into this area and we haven't noticed it coming. We're going to have to be very attentive to the fact that going without restraints in some patients means they will die earlier, and that we're going to have to come to terms with whether that is all right or whether we are obliged to see to it that they die later and thereby impose restraints in order to treat.

That links to a fundamental question that I think even this panel has had some split on that I expect will have a deeper split as we get into the afternoon, and that is the question of whether restraints for incompetent and demented persons are an affront to basic civil liberties or whether they are an issue in a treatment plan. And, if they are an affront to basic civil liberties, then at least to a large extent it doesn't matter if the patient, on some grounds, is disadvantaged by being restraint-free; whereas, if it is an element in the treatment plan, then that is the whole ball of wax. Is the patient advantaged or disadvantaged by being restrained in one way or another?

If we are talking about it as an element of the treatment plan that can be judged on the merits, then an informed consent model applies and someone needs to be informed as to the likely outcomes with and without this mode of treatment and a decision made on that basis, in which case there clearly will not be zero restraints.

If, on the other hand, tying people down to their bed rails for the rest of their days is an affront to basic civil liberties, and that no one should die that way, then even if a particular person would be advantaged by being restrained, they should be liberated.

I think we have to get clear which image we really have in mind and which way we with the regulations and legislation and so forth to unfold, because the degree to which we tolerate explanations of restraints turns on this question.

Mr. Lewis. Is there anyone on the panel who would like to respond to that statement?

Ms. Rader. I would.

In my presentation I said that there is 50 to 60 percent of the population that is fairly easy to get restraint-free. There is another 30 to 40 percent that would require additional resources, education, and consultation. And then there is that 5 or 10 percent who, I believe, Doctor Lynn is referring to that you just can't figure out how to get them restraint-free within the current constraints of our ethical legal-medical-social system.

For a number of those individuals we have been able to decrease the number of hours per day they are in restraints or decrease the number of days that those restraints are used. A good example that comes to mind is a common one, in which the person who has had a stroke, difficulty swallowing, speaking, and understanding and their ability to progress is unknown at this time. But if they can't eat and if they don't get a feeding tube they may die because they can no longer swallow. Yet, unless their hand is tied or someone is constantly at the bedside, they are likely to pull out the nasogastric feeding tube. Those are the really tough cases.

When you are the clinician it is very difficult and these are ethical dilemmas, which means there is no clear path. We don't have many guidelines yet in how to proceed. The various court decisions and the push toward prolonging life at all costs in our country create a very difficult situation for the caregiver.

What I tell my students and the nurses that I speak to regarding the fear of litigation is that there is freedom in the new push toward no restraints because you can be sued either way. So that fear of litigation can no longer be the basis for your nursing decisions. Your salvation is in individualizing your assessment and approach, documentation of risks and benefits, and including the patients and/or residents, and families in the decisionmaking process. If those things are in place, you have covered your bases.

Mr. **Lewis**. Other questions, please?

STATEMENT OF STEVE WARREN

Mr. **Warren**. My name is Steve Warren of the Skil-Care Corp. One point that came off clearly today is that, as a manufacturer of restraints, I really don't understand what a restraint is after today. We talk about elimination of a classification of devices, and I don't think very many people in this room could talk about what we're eliminating. Specifically, if we talk about a postural support where the patient has access to the means of closure, thereby the patient having autonomy, we're talking about eliminating that classification of process. And if we are, has the Kendal Corporation attempted to try products where the patients had access to the methods of closure?

Ms. **Blakeslee**. No, the Kendal Corporation has not used devices such as that. But in this whole argument about what are and what are not restraints, I think, as in everything we do with people in long-term care, we have to come back to what the resident wants. If the resident feels comfortable in a device that keeps him in a chair, if the resident can get out of that device any time he wants to, then that is not considered a restraint. The resident isn't feeling restrained or confined. The resident is feeling just as free in that device as they are out of it.

I think we have to come back in all that we do to what the resident wants and stop considering the fact that once they are admitted to a long-term care facility that someone has to take over control of their lives.

People need to remain in contol of their lives because when they lose that control they get sick, they get demented, they become dependent, and they require a great deal of care.

That has to do with the whole issue around the nasal-gastric tubes, too. The use of a nasal-gastric tubes is now as rampant as has been the use of restraints for the last 40 years. That issue needs to be addressed, too.

We have to continue to look at what we are doing to the old people in this country. It needs to be addressed.

STATEMENT OF KAREN SCHOENEMAN

Ms. **Schoeneman**. Good morning. My name is Karen Schoeneman. I am currently with the Health Care Financing Administration, but I am not speaking as a representative of that agency, but rather as someone who has worked as a case worker in nursing homes for 17 years.

I would like to direct the attention of those up front to postural restraints and the observation that I have made in this time that wheelchairs and gerichairs seem to me to be improperly designed for the comfort of the human frame. I would hope that those recommendations which are being made to the Senate would ask people with backgrounds in wheelchair design, engineering, occupational therapy, whatever the necessary expertise, to come in with them and look at redesigning wheelchairs so that we do not need 70 percent of these restraints which are for postural reasons.

STATEMENT OF DR. RICHARD LINDAY

Dr. **Linday**. I'm Doctor Richard Linday from the University of Virginia.

I would just respond to the very appropriate previous comment to say that at the university we have a fine Department of Wheelchair Design. Recently, about a year ago, the first nationwide conference on technology for wheelchairs, particularly looking at dementia patient problems, was convened here at Dulles Airport. So I think, very honestly, there is a great future for redesign, particularly when one looks at the concept that the wheelchair in long-term care is not used as the wheelchair would be used by handicapped individuals to go from point A to point B. It is often used as a repository for sustained periods of observation, which is never was intended to do. I couldn't agree more with the fact that redesign is appropriate.

So I think that hopefully we will, in fact, work closely with you and would be open and receptive to ideas and thoughts about product design.

One of the interesting things about product design is that getting new design on the market is often inhibited by fear of litigation for a new product and product design, so I think manufacturers are well aware of that.

STATEMENT OF MELISSA DUNCAN

Ms. **Duncan**. I'm Melissa Duncan, Rock Creek Manor Nursing Home.

Our administration has taken a very active role. For those who wish to have no-restraint environments, my suggestion might be that we concentrate on getting the actual residents, when they enter a nursing home facility, to consider durable powers of attorney where the resident, themselves, making the decision of what their care is going to be.

As a recreational therapist I ask that the government, administrators, nurses, et cetera—because recreational therapy is not an exact science, it is often not given much validity. You keep speaking about the excess energy of these individuals, these wanderers, that they need something to be done with their time. The average facility in this country has one recreational therapist for about 60 patients. When you're looking at trying to occupy their time, that just isn't much consideration that we can give to the individuals. But because it is not an exact science it is often ignored.

Ms. **Blakeslee**. I would like to say that the recreational therapists do great work in working in a restraint-free environment. They are a very important part of the team that cares for older people.

STATEMENT OF ARNOLD GISSIN

Mr. GISSIN. My name is Arnold Gissin. I am the Administrator of the Jewish Home of Rochester. We started to go restraint-free 5 months ago. There have been some problems but, for the most part, it has been very successful.

First, let me reiterate the role of recreational therapy. You can't go restraint-free without adding recreational therapy and emphasizing it.

I think the point I'd like to make is that I hear a lot about litigation. I'm afraid of everything in this business, but I'm afraid of litigation least at this point. What I'm afraid of—and I heard Ms. Rader make the point—is the fear in blaming when someone falls. When we go restraint-free in the few facilities that are restraint-free, we are somewhat out there alone right now. We are changing the community standard. The standard in Rochester, NY, is to restrain. The standard in other places is to restrain. I'm damn scared when someone falls. My staff is fearful because the regulators—and there are no bad guys. I'm not trying to point—are thinking different thoughts. This hasn't happened to us, but I'm very fearful. Will the press come in? Will the regulators come in? Will they ask the same, old questions? You can always have the advantage of hindsight to ask these questions.

So we really have to start looking. There are some changes going on. There are going to be some falls. There are going to be some injuries. But there is going to be some real freedom, and that's what we want.

Thank you.

[Applause.]

Mr. LEWIS. Any response to that?

Ms. SIMMONS. I'm not going to respond to that, but I'd like to respond to the lady that suggested about the durable power of attorney. That is clearly an optimal document that should be for any patient entering a nursing home. But, sad to say, the vast majority of patients entering a nursing home are beyond the ability to be able to sign a durable power.

I would have to ask all of you, in knowing what age I am, if all of you have signed a durable power of attorney. Remember our first speaker this morning? His wife entered the nursing home at a very, very young age and probably did not have a durable power of attorney then.

So you are dealing with a number of person in nursing homes that cannot speak for themselves and do not have the ability to designate their wishes to someone else.

Mr. LEWIS. Marshall.

Mr. KAPP. I was going to comment to the gentleman from Rochester that I think he is absolutely right. It is probably not realistic to expect individual facilities on their own to be the standard changers. No one wants to be the legal precedent setter. That's why I think there is an important role for the industry as a whole, through trade and professional associations working collectively, to move standards of care in the appropriate direction so that when you, as an individual facility, act progressively and there is an occasional bad result, you are not hanging out by yourself all alone either in terms of adverse publicity or litigation.

Ms. **Rader**. I'd like to make a comment on that. One of the legal concepts that we have used in Oregon is called a window of lucidity—persons with dementia may not have an understanding of complex concepts, but they may have a window of lucidity where in that moment of time, related to a specific concept, they are able to understand the meaning of an act or request and can express their preference. Competency or capacity therefore may not be a global concept but it may be context related. You look for a window of lucidity to determine the resident's wishes.

I think, from a clinician's standpoint, going back to the feeding tube issue, a lot of people with the feeding tubes wil continuously pull it out. A legal debate exists as to whether the act is because it is an irritation or because it is an indication of the individual's wishes. There is no consensus legally or otherwise, but I think most clinicians feel that when a person continuously pulls out a feeding tube it is an expression of their wishes and an indication of their sense of burden. This is controversial. But when you are at the bedside, it often feels as if their attempt to remove the tube are a true expression of their deepest wishes.

STATEMENT OF ROSEMARY HESTON

Ms. **Heston**. I'm Rosemary Heston, a rehabilitation nurse clinician, Hastings on Hudson, NY.

I believe that there is another myth that I would like to address and that has to do with positioning.

You know, the wonderful illustrations we see on the brochures for restraints and, in fact, one of the big companies—Posey, I believe—has family members who pose for the pictures on restraints. And you see somebody with posture the like of which none of us can show this morning. We're slouching or we're sliding. You see this healthy-looking older individual sitting bolt upright in those horrid wheelchairs.

And, also, the State is going to come in and look at our residents and make sure that they are sitting perfectly straight, bolt upright. This is not human.

My feeling very strongly is that the remedy is not to put a restraint on or bolster them into a fixed position, but to acknowledge the fact that human beings need to move and to help them to stand up, preferably to walk, if possible, and to reposition them.

Ms. **Blakeslee**. Amen.

STATEMENT OF FARLEY WADE FARBER

Ms. **Farber**. My name is Farley Wade Farber of the National Association of Activities Professionals.

As an activities professional, the issue of posturing doesn't often come up to us, but what I am often told in facilities where I have worked is that this person wants to get out. What do you do for them? Some facilities use locked units, some facilities don't. But we definitely have a need for the residents who have a need to go outside daily. They want to go to the corner store. They want to go down and buy cigarettes. They want to go to the bank. They want to go to the hairdresser.

I'm interested in knowing how many of you address that situation.

Ms. **Blakeslee**. We address it whenever the need arises. I know some facilities have alarms on their exit doors. We have them at night, not in the daytime. But the whole issue of dealing with residents who are restless and anxious and on the move is, number one, it is not just a nursing problem. Everybody in the facility must be involved with this resident and understand this resident and be on the lookout for where they may be so that if someone is mowing the lawn they are allowed to stop mowing the lawn and go and see Mrs. Jones and see where she is going and what her problem is. We can't hang the whole responsibility on the health services. It is everybody in the facility.

Later on in one of the panels I believe Beryl is going to show some of the little things we do to try and interfere with this wandering habit, but it all comes down to looking at the individual as a person and understanding their needs, understanding their agenda, and coming up with something that fits that person tailor made.

Ms. **Rader**. Could I respond to that also, please?

Mr. **Lewis**. Sure.

Ms. **Rader**. I spent a lot of time studying the problem of wandering behavior, and one of the things we do, going back to what Jill was saying about identifying the underlying need, is to find alternative ways to meet those needs. For example, one gentleman came up to me and said he had to leave because he had to go mow the lawn. There was no one at that moment that had the time to go out with him, although on many occasions that did happen. So I looked at what he wanted. He wanted something useful to do. That was the underlying need behind the desire to mow the lawn.

I said, "Gosh, I know your lawn needs to be mowed, but there is something that I need help with and you're the only one that I can think of that could help me with this right now. Would you be willing to help me with this project?" He said, "Sure." So then I had to quickly think of what my project was going to be, but we got him redirected and he was able to be of useful service, and that's what he needed. So sometimes—redirecting the need can work. It can be really exciting to identify the underlying need and create new ways to deal with them.

STATEMENT OF NEVILLE STRUMPF

Ms. **Strumpf**. I'm Neville Strumpf from the University of Pennsylvania.

We have heard a number of comments about the history of physical restraint use today, and I would like to just provide a historical footnote to all of that. Along with Lois Evans and Kathryn Stevenson, we have just done a very extensive review dating back to about 1800 to look at the use of restraints. Some of you may be aware that there was a very powerful movement at the beginning of the 19th century to release the mentally ill from physical restraints. A considerable debate went on for the entire 19th century, primarily in the psychiatric community, of restraint versus nonrestraint. The arguments are extremely similar to the ones we use today in terms of what can be done, what can't be done, why people need to be restrained or why they don't.

By the conclusion of the 19th century, what was fascinating was the enormous cultural differences that emerged between Great Britain and the United States, with a much stronger nonrestraint movement among British psychiatrists as compared to those in American who used arguments that included things like there was something unusual about American insanity which required restraint. [Laughter.]

In any event, we then took a look at all of the journals and early nursing textbooks that were published from 1885 onward to see if we could really trace this restraint use. Indeed, there always was a place for restraint. We were quite surprised to discover various types of jackets, chairs, cot sides, et cetera, which appeared in pictures in some of these journals, but always with the caveat, "Don't use these unless it is absolutely necessary." In other words, an argument for proper restraint.

By the 1950's there was an emerging consensus in the literature that safety was very important. We uncovered one article showing that the California Bar suggested that all hospitals in California put side rails on the bed and possibly even use restraints because it was very dangerous for patients to be sort of at liberty and loose and falling.

Of course, we now see a very different kind of picture, an entrenched practice I think culturally and otherwise, and with a very, very large percentage of older people restrained. I think we want to consider that history in our discussion because there were strong movements to get rid of restraints. Restraints have been removed largely among the mentally ill. Now we have seen steadily a rise in that use.

So I think as we consider proper restraint versus nonrestraint and the research that we need we might want to remember that history.

Thank you.

Mr. LEWIS. Thank you very much. Is there anyone who would like to make a comment about that?

STATEMENT OF MARY HARPER

Ms. HARPER. I am Mary Harper from the National Institute for Mental Health. I know this topic is primarily about physical restraint, but I want to make a comment. During the last data for the National Nursing Home Survey my agency did a secondary analysis looking at the area of psychoactive drugs and their use in nursing homes. We found that 62 percent of the patients were on psychiatric drugs, whereas only 5 percent had psychiatric diagnosis.

I am afraid, then—and our deliberation pertaining to physical restraint we have to be careful that we don't go from physical to chemical restraint. I am a strong advocate. As a psychiatric nurse for the past 45 years I am a strong advocate to well-supervised, well-trained staff and individually assigned staff, and I guarantee you that will reduce restraints in half.

Thank you.

STATEMENT OF VIVIENNE WISDOM

Ms. **Wisdom**. My name is Vivienne Wisdom. I'm the executive director of the New Hampshire Health Care Association. We have taken on, as our own project, this year, the reduction of the use of both chemical and physical restraints. I'd like to tell you that we think we have been very successful. We have at least three facilities that are restraint-free. I'd like to thank Joanne Rader. She is one of our heroines because we use her. Working with the confused elderly it is very helpful. And we thank Sarah Burger, who is with the National Coalition, who really first gave us the idea of doing that.

But I'd like to support the comment that was just made. Our first efforts were in the area of the use of chemicals. At our last survey, the people who responded had reduced the use of chemicals about 74 percent; 54 percent reduction in restraints. It keeps getting better.

We still have problems, and we don't think every facility will be restraint-free, but we are looking forward to more consultation, more information, and more assistance.

We thank you for your efforts.

Mr. **Lewis**. Any other questions?

STATEMENT OF JOAN REED

Ms. **Reed**. My name is Joan Reed, Health Plus of Michigan, a representative of an insurance company, formerly director of nursing of a skilled facility.

Since the focus of nursing care is interdisciplinary, I felt that there should be at least one nurse stand up and talk. I feel that we have a full care plan all the way from durable medical to activities. I am involved with sharing managed care with options of home or to a nursing home. I want to say that from my background as a nursing home director of the skilled facility in our area that there is vast, vast assistance to families and very good quality of care that is being provided. Unfortunately, quality of care does not always sell newspapers, so we, across the country, are becoming even better with quality of care when we know of the work that needs to be done with clarifying some lack of care.

I would like to address all of you that have nursing leadership to be sure and speak up to the representatives of your individual States of the concerns. I think that there is a need for restraints under doctors' orders and physicians' observations. I think there are some options to look at with some new areas to go into as we enter into the 1990's because the care of a resident has increased with intensity, as well as the support systems and the mobility of families.

I would like to also address any of them on the panel that we, as nursing home representatives, are also concerned as to the rules and regulations that are increasing with our quality of care: Is reimbursement being able to be increased so that we can implement some of those needs? As the rules encourage us to give that quality can also—the representatives of the purse strings allow us to do that.

[Applause.]

Mr. LEWIS. Is there anyone who would want to comment or respond?

STATEMENT OF BUD SWARTOUT

Mr. SWARTOUT. My name is Bud Swartout of Clearview Electronics Corp., Newark, DE.

The topic here is to untie the elderly, and the next question would be how you do this. When you get back home and tomorrow morning when you talk to your bosses, what is your answer to that question?

There is hardly an answer to be found here, but you are lucky. I happen to be a manufacturer of an electronic Posey that electronically lets you know whether a person is getting out of their chair or not. Thank you. Here it is if you want it.

Mr. WARREN. My name is Steve Warren from Skil-Care Corp. It seems like we're talking about banning or minimizing or eliminating a category of products when, in fact, there may be some restraints out that are used in the industry that are really not good restraints. For example, I hear a lot of talk today about a vest restraint. As a manufacturer of that category of products, I will admit I think that is probably the least effective device among that category of products.

Why is there not more emphasis on improving that category of products, making them more humane, more feedback with manufacturers before you consider the possibility of just eliminating the device? It is almost like talking about eliminating automobiles when you have a few bad cars on the road. You look to improve the lot. There is really no talk about alternatives within the category of restraints.

Ms. BLAKESLEE. I'm sorry, sir. There are a lot of alternatives out there, but they don't include tying people to their beds and their chairs.

Mr. WARREN. I could accept that, but have you tried them?

Ms. RADER. Could I respond to that also? I think we are definitely overusing the product, and an automobile does not restrict a person's freedom. There is a big difference. There is definitely a case to be made for improving the product and improving chairs and things like that, which will give us a lot of better alternatives than we have. I don't think we are taking the product to task; I think we are taking a health care system to task that has abused a product. I think there is a big difference.

STATEMENT OF MARIAN CARROT

Ms. CARROT. Hello. My name is Marian Carrot. I'm a physician and geriatrician at George Washington University.

Previously I have been a medical director of two 200-plus bed community nursing homes. I have worked in a number of nursing homes, including the Washington Home and Thomas House locally, and several others in different parts of the United States.

I just want to point out that restraints may be put in place by nurses, but they are ordered by physicians, and physicians don't know anything about nursing home patients—most of them. They don't.

I think I do, and I think most of our group does, because we have been there. You have to be physically present in the nursing home to see what goes on there, and the average doctor spends about 20 minutes a month at the nursing home signing charts and doing recertification and saying hello to the patients. They don't know what goes on there on a daily basis. They have no concepts to what the alternatives to restraints are, of what may cause agitation, of what may be used to alleviate agitation other than restraint. And yet, in the care plan and all the regulations it says that doctors must order these things and doctors must develop these care plans. Well, the physician is not the right person, in most cases. In many cases restraints are ordered to get nurses to stop bugging you.

Ms. BLAKESLEE. Absolutely.

Ms. CARROT. That's the truth.

Ms. BLAKESLEE. Do what you want, just don't call me.

Ms. CARROT. So I think that since it is the doctors who order the restraints where we have to—and I, personally, believe that it is probably impossible to completely and totally eliminate the use, but I think the use could be drastically reduced by the right approach. We need to educate physicians that this is not necessary and there are alternatives.

Ms. BLAKESLEE. But as I understand the new regulations, it has taken that physician element out of that. They don't have to be ordered.

Ms. CARROT. Is that true?

Ms. BLAKESLEE. And we——

Ms. CARROT. I don't think so.

Ms. BLAKESLEE. We, as caregivers, have to prove by documentation, what we're doing—that everything else possible has been tried before we resort to restraints.

Ms. CARROT. That's all I really wanted to say. Thank you.

Mr. LEWIS. Thank you very much.

Ms. SIMMONS. Excuse me. That's not true, Jill, that the new regulations do not decrease or eliminate the need for physicians to order and/or approve the medical treatment plan of residents in facilities.

Ms. BLAKESLEE. I stand corrected, but I understood that they no longer played that important role.

Mr. LEWIS. We may adjourn now. We are adjourned until 1 p.m. Please be prompt in coming back as we will start at 1 p.m.

Thank you very much.

[Recess for lunch.]

AFTERNOON SESSION

Mr. LEWIS. Our first session this afternoon is entitled "U.S. and International Experiences in Restraint-Free Care: Comparing Notes." Our discussion leader this afternoon for this first session will be Curt Torell.

Curt Torell serves as Director for Education and Organizational Development at The Kendal Corporation. Curt was first associated with Kendal in 1983 as an independent consultant assisting in employee education. He began full-time employment in January 1985, as both Director of Education and director of an academic geriatric center. He has played an important role in the creation of the "Untie The Elderly" program and the development of educational materials supporting an organization's implementation of a restraint-free policy. In addition, Curt has a Ph.D. in Organizational Development from Temple University.

Curt Torell.

STATEMENT OF CURT TORELL

Dr. TORELL. Thank you.

Good afternoon. It is a privilege to be here and to help surface the various issues surrounding restraint-free care and the use of physical restraints. For those of you who are joining us this afternoon, we welcome you, and we hope that you will benefit from this afternoon's session.

This morning, you heard about the problems in using physical restraints and how alternatives can be used. You heard about changing attitudes and beliefs in order to create and implement these alternatives. You also heard some concerns regarding 100 percent restraint-free care. Before lunch, a panel addressed some of the legal concerns. They suggested that litigation may be a greater threat when restraints are used, particularly when they are misused, than when they are not used at all.

This panel will respond with observations where restraint-free care has worked. Their perspective from the practitioner's world questions the validity of many myths that we hold in defense of physical restraints. Their practice demonstrates that restraints are not necessary and that their elimination improves not only the quality of care for the residents but also the spirit, health, and well-being of the caregivers.

Our panelists are professionals who share experiences from this country and others. I will introduce all four panelists, and they will present in the order that I introduce them.

The first, Beryl Goldman, is Associate Director for Health Services at The Kendal Corporation and has played a critical role in facilitating a restraint-free policy change in several nursing homes. She is currently project coordinator for a Delaware Valley demonstration project to eliminate physical restraints from nine long-term care facilities. She will review her work with these facilities.

Second is Henrietta Roberts, Executive Director of Stapely in Germantown, located in Philadelphia, PA. This is one of the nine facilities that are in the demonstration project. It is through her support that the nursing facility, over the past year, has successfully made the transition to a nonrestraint policy. She will share some specific responses as an administrator.

Our third panelist is Lynne Mitchell-Pedersen, who serves as Clinical Nurse Specialist in Geriatric Nursing at Saint Boniface General Hospital in Winnipeg, Manitoba, Canada. It is through her leadership that the hospital's Department of Geriatric Medicine, a

188-bed area including a 28-bed palliative care unit, changed its policy regarding the use of physical restraints in 1981 and 1982. She also will share her experiences through this process.

Our last panelist, Carter Catlett Williams is a nationally recognized social work consultant in aging. She has worked for many years with older people in their homes and through their transition into nursing homes. She visited Scandinavian nursing homes a few years ago to learn more about their individualized approach to care and the ways in which the elderly are cared for without restraints. She will summarize her observations.

Our first panelist is Beryl Goldman.

STATEMENT OF BERYL GOLDMAN

Ms. GOLDMAN. Thank you, Curt.

As you heard already, we have been working on a demonstration project with nine facilities in the Delaware Valley. This actually started about 3 years ago when we worked with Friends Hall, an 80-bed free-standing nursing home in West Chester, PA.

We helped them change from using physical restraints to not using them. They had been using physical restraints for about 20 years, and we worked very closely with them in changing. The process took about 3 months, and to this time, which is 3 years later, they still restraint-free.

Because of our experience with them and how well things really happened, we decided to pursue working with other facilities in the same endeavor. We began about a year ago with nine facilities in the Delaware Valley. Some are continuing-care retirement communities and others are free-standing nursing homes.

They range in size from 57 beds in skilled and intermediate, to 130 beds. Also they have between 15 and 65 percent Medicaid residents. As Jill mentioned earlier today, the staffing at those facilities has been running between 2.5 and 3.5.

In each one of these facilities, we have been working closely with various groups that I will identify in a moment. The facilities are at different stages in the transition. Some are very early, in discussions with boards and other staff in the facility. Others have set policies that state new residents will not be restrained. That is where they thought they needed to start.

Some have come to the point where they are 90 to 95 percent restraint-free, and even others, as you will hear from Henrietta Roberts about Stapely Hall, have actually become completely restraint-free.

We have found that there are at least seven groups in each one of the facilities that we need to work with. The first slide identifies them: the administrator, the board of directors, department heads, because they all need to be involved in the process, the staff, physicians, families, and other residents.

We have met with each one of these groups on different occasions and have used a variety of techniques in getting to them, such things as inservices, support groups, slide presentations, problem-solving sessions, and actually, one on one consultations, whatever we have needed to do to help them through the process.

Most of our time has been spent with the staff. We have probably been giving most of our efforts to them. We find that if we work with them in looking at the easiest cases first, where they can see success, then they are able to move on to the more difficult ones.

We do not start out with the people who have the N/G tubes or start out with people who have all kinds of problems. We start out with the residents in the facility that no one remembers why they were restrained in the first place. It just happened. That person who has always been in a Geri chair or that person who has always had a seat belt restraint on.

We have the staff identify the people that they need to work with and they start seeing successes. One success really breeds another.

In most of the facilities, once they have identified the residents, they have been able to eliminate at least 50 percent of the restraints in a very short time. That has really been very encouraging for all of us.

In working with the staff, we do pre-intervention surveys. We want them to have a chance to express how they really feel about restraints, to talk about the concerns that they have and why they feel it is important to use them.

The last question of the survey is: would you support a no-restraint policy? The overwhelming response is, "No." However, in later conversations with the staff and in their post-surveys we have found real changes in their relationships with and their perceptions of the residents. They see them as individuals and not just as another task to complete or another thing to tie up.

One area that many of the facilities have been looking at is dealing with primary nursing care or resident-centered care. This is something that we have been doing over the past couple of years and we have found that it has really helped in getting staff to identify the residents as people.

We have the same nursing assistant care for the same resident day after day. They become a part of that person's life. They get to know their habits and what works for them and what does not. This has really been very helpful.

Also, we have been discussing possible alternatives. As one of the directors of nursing said, they have been mainly commonsense types of alternatives. They have not spent large amounts of money for them.

In all of these facilities, they have not increased staff because restraints have been eliminated, and they have not experienced any increase in cost because of it. The only facilities that have had increased costs are those that put a security alarm system at the doors. Those facilities have incurred an extra expense.

I would like to go through a few of the things that the facilities have come up with, some alternatives that they have used that seem to be working. In the first case for a wanderer, rather than tying the person into a chair or having the person sit in a Geri chair, they have come up with a variety of techniques.

The first is putting a yellow strip across the doorway of an alert resident who has been experiencing a lot of visits by a cognitively impaired or wandering resident. This material is attached by velcro and the alert resident is able to remove that whenever they would like to. For some residents, this works extremely well.

Some wanderers will just to underneath of that, so you really have to get to know the individual. That is where the individualized care really comes into play.

Another example is the use of a cafe door. This can be put at the doorway of a resident who wanders. As the door opens, a small buzzer above the doorway is activated and alerts the staff. This has been made simply by our maintenance department and works for some people.

Another possibility is using plastic strips as lines across the doorway or as a grid. Once again, it works for some residents and not for others.

Many wandering residents really need that constant motion, the chance to keep moving. Rocking chairs are ideal for many. They really work quite well. There are also footstools on a rocker, where the legs can be elevated and they can rock.

For the resident that we are concerned might fall out of the chair, who leans forward and has a problem, we have had great success using wedged cushions. Many times, people find that just having that, where it tips to the back, really helps a person and prevents them from falling forward.

Another thing that can be used is very comfortable seating for residents. Not all chairs fit every person. It is very nice if we can have residents or families bring in their own furniture, chairs that they have been comfortable sitting in and ones that fit the persons. Many times you go into facilities and find short women sitting in very high chairs with their feet off of the floor. There is no way they can be comfortable and it also inhibits their walking around in the future.

Another thing we have been using is anti-tipping devices. These can be purchased through the wheelchair suppliers. They can be attached to any wheelchair on either the front legs of the chair or on the rear legs, depending on what you are trying to accomplish. All of those alternatives seem to work quite well for the right person.

The recliner chair is used often by many of the facilities for people who have problems remembering that they cannot stand up on their own. They are able to sit in the recliner chair, which is a chair like they have had at home all their lives, where they can remain very dignified and still have their self-esteem, but which makes a little more difficult for them to get up easily on their own.

If they are in an area where they are able to be viewed by staff and by other people going through, it makes them feel like they are part of what is going on, and they are still very approachable. They are sitting in a very regular type of chair. People can really watch in case the person is trying to get up on his own.

What we are finding overall is that staff are becoming very creative. They are looking at the people as individuals, not as just another task that has to be accomplished during the day.

We have learned very much that we can change their behavior, but it takes a long time to change the attitude. The post-attitudinal studies are helpful, but I really believe that it will be even more informative in the future to determine if their attitudes have changed for the long term.

As I mentioned with Friends Hall, 3 years ago, we did not really survey the staff, but we have gone back to them recently to see how the staff feels now since they have not been using restraints. The remarks have been very positive.

One that I would like to conclude with was shared by an L.P.N. who worked there, who I must say was very resistant to the idea of reducing or eliminating physical restraints. She thought that it could never happen. The comment that we have here will show you how far she has come. She said, "I wouldn't work any other place now. I wouldn't have said that or believed it 2 years ago."

Thank you.

STATEMENT OF HENRIETTA ROBERTS

Ms. ROBERTS. Good afternoon. I am very pleased to be here today to represent my staff at Stapely in Germantown, because it was indeed the efforts and the energy of the staff that allowed us to become a restraint-free facility.

It began by our staff going out to Kendal to visit the director of nursing, the activities person, and the nursing home administrator. They came back saying, "My goodness, it's a different world out there. It's so calm." They said that we could do it, and they set about doing it.

They spoke to me—I am the executive director—and said, "Can we try this?" I said that it was a wonderful idea. The mission of our organization at Stapely is—the facility was founded in 1904—I might mention, with the nursing home being added in 1984—the mission of Stapely has always been to deal with the individual, to see the individual as a person. It was difficult when a person who lived in another part of our facility went into the nursing home and their friends may have come to see them and saw them in restraints.

When we got the buy-in from the executive director, I went to the board and they said, "Okay." We spoke to families, and we began to become a restraint-free facility.

They set a goal of untying or unrestraining at least five people each month. They just went around and took them off and people did not even know what was happening. It was really going great.

Then there was the pre-restraint questionnaire, which the Kendal folks had given us, asking staff their feelings about restraints. To the question: Why are you restraining people, the answer was, "To keep them from falling or hurting themselves." Then we started asking: Is that the way you have to do it?

We found that staff began walking the residents more. They did creative things. The activity person went through the facility with a resident. She would take him to an office with her and he would answer the phone, maybe not appropriately, but at least he wasn't tied. That was great.

The other group that is very important in a restraint-free facility is other residents. You do have the people that will wander, but you know, they started saying, "That's okay. She will go out," if a patient came into their room. They were much calmer because they knew that when staff came to remove that person from a room, they were not going to take them and tie them in a chair. They were going to take them to another area or work with them in giving them something else to do.

The feedback was good. The families are pleased. When the facility used restraints, people accepted it, but I can not tell you how much the families have been pleased by this. Families come in and observe that there is a whole different environment now. It is calmer and quieter.

The nursing staff and the housekeepers and the maintenance people—you have to have a buy-in from your whole facility. The relationship with residents and staff is very good.

We have a statement around Stapely called WIFM—"What's in it for me?" With our staff, we did a lot of WIFM. We convinced them. Patients that were incontinent before, when they were free of restraints, actually began to toilet themselves. They began to go to the bathroom by themselves. What's in it for me? The staff did not have to take care of an incontinent patient. That was good.

The sense of humanitarianism, the sense that you were dealing with a person, the resident—Mary Smith was really not "one of them." She was Mary Smith and Mary Smith is a person. That has made a great deal of difference. Not a lot of honey-sweetie things—we won't do that at Stapely. But, "Mary Smith, let's go look at the trees outside." That makes a great deal of difference in our facility.

The patients are easier to care for. When a nurse takes someone by the hand, they are not taking them to tie them. Therefore, you eliminate the combativeness or the hostility from the patient, or the fear. "I am taking you here to sit down. Let's talk or be involved in an activity."

Our activity person centers activities around food, so she has "Make Your Own Sundae Day." She has one of our former wanderers who used to go someplace every time he had the chance, and he helps her get the ice cream out, so that goes well.

The families are very pleased about this. We have not had any adverse comments from our families. They don't see their loved ones tied down.

Falls—people fall at Stapely, but no more than when the facility used restraints. That was a surprise to me. If I had any concern—I heard talk about litigation and that kind of thing and I know how my board feels about that. We did not have fewer falls, but we certainly didn't have any more.

We kept the State agency, the Department of Health, apprised as to what we were doing. They are very pleased. They came to our facility and said, "Are you one of those nonrestraint facilities? That's good."

The other thing is the caregivers. We believe that it has lessened their fear of aging. "I don't have to face aging with someone tying me down or putting me in a chair, or something like that. Maybe there is another way to go about this."

The other thing is—selfish reason—but we market our facility. It is important that we have occupancy at Stapely. You market a facility that does not use restraints. It is an honest way to market your facility.

I am very happy to be here to talk about our experience. Our staffing on our intermediate unit is 2.6. On our skilled unit, it is 2.8. That is what our staffing was when we started.

We have been in this a year. We sort of plotted out how we were going to go about it, and I am happy to say that in October, the nursing home administrator removed the last restraint from the facility.

There is a game called, "Into Aging." Perhaps you have heard of it. That is part of the orientation of new people coming in, because you do get staff who have worked in other places. When they come to our facility, we have to let them know that this is the way we do it at Stapely. The easiest way is to tie them in a chair, play the game, and give them a certain sensitivity to what we are trying to do.

Thank you very much for this opportunity.

STATEMENT OF LYNNE MITCHELL-PEDERSEN

Ms. MITCHELL-PEDERSEN. Thank you.

I come from Saint Boniface General Hospital in Winnipeg, which is an 850-bed tertiary care hospital affiliated with the University of Manitoba. It is owned and operated by the Grey Nuns and is the oldest hospital in western Canada. It is situated on the banks of the Red River. Those of you who don't know where Winnipeg is may know where the Red River is.

The reason I am here today is that in late 1981 and early 1982, our department made a change away from using physical restraints. Within a 1-year period of time, we achieved a 96-percent reduction in their use, which has been maintained and even enhanced to this date.

To give you a sense of our department, I work in the Department of Geriatric Medicine, which is a 156-bed unit including a 20-bed palliative care unit. We also have a 15-space geriatric day hospital.

To give you an idea of the kinds of patients we have because people often say to me, "Your patients aren't like ours. It's all right for you to move away from restraint use, but we are different." About a third of our patients are those elderly who are acutely ill, admitted through emergency or directly from the community. Approximately another one-third are those admitted for rehabilitation, including stroke rehab and orthopedic rehab, including amputee rehab. The other third are those people who have been paneled for placement in permanent long-term care and are awaiting that placement. That gives you a sense of the population group that we work with.

What I want to do this afternoon is to tell you a little bit about what happened for us; why we took this course, how we did it, and where we are at this moment. To start out with why, our story starts with a very tragic event where a patient, not in our department but in another area of the hospital, strangled in an improperly applied Posey jacket.

There was an inquest following this accident and recommendations were made to our board, including one that said that all of our staff must be taught how to use restraints properly. It is strange that we always say, "Let's use them properly," instead of, "Let's do away with them."

At any rate, our board accepted that recommendation. Our continuing education department made a very excellent film on how you tie people up well, and every front-line staff person in the hospital had to view that film and sign in that they had viewed it. We had a big 3-day blitz for everybody to look at this film on using restraints.

That blitz coincided with the arrival of our new head of Geriatric Medicine, Dr. Colin Powell, who is a British geriatrician. He walked in the door from Britain, where restraints are much less commonly used, to watch the whole parade of the entire hospital staff marching off to see this film on how to tie people up.

He was upset to say the least, and challenged our vice president of nursing about what was going on here. She said, "All right; if you're so smart, show us what else to do." Of course, doctors don't know that kind of answer, but he very wisely took it to a group within our department, the advisory committee, which is comprised of the heads of each discipline within the department, social work, OT, PT, as well as all head nurses and physicians. You can see that this is a group that had a lot of influence and power within the department.

The group decided that, first of all, we would try to create some policy guidelines around use or nonuse of restraints. Second, we would create a video tape as an education intervention, and finally, we would do a grand and glorious research project, a before/after restraints, intra-ward, inter-ward, and so on.

All this discussion got underway, and I will tell you specifically what we discussed in a moment because I think it is relevant to how we achieved our change. We started working on this video tape which looks at alternate ways to care for patients instead of using restraints.

I was the producer of this video tape and we had very many people from our department involved, including cleaning ladies, ward clerks, and everybody else. It was a big production, a big nuisance, actually, to everyone in the place.

By the time we got the video tape made, restraints had disappeared, and we couldn't bring them back just for the sake of doing the research project, so our research was spoiled. We have kept data which I will share with you in a moment.

Before I do that, I want to tell you what restraints I am talking about. I know that we had a discussion this morning about definition of restraints. I will tell you what we looked at.

All of these on the slide, we consider restraints. We had no way to count the use of bed rails and geriatric chairs, so they are not included in my data. We had ways to count these other things, so we could include them. However, when we took a look at all the incident reports around use of geriatric chairs and the very, very bad accidents that can happen with their use, we just made the decision to abandon them. We just took them all away.

Most geriatric chairs are not properly constructed. They have an inadequate base so that if people tip over in them, they really smash and really have some serious injuries. So we just ditched them at that point.

We still contend with bed rails because it is impossible to buy an institutional bed in Canada that is low enough to the floor so that an old person can put his or her feet on the ground from it. This bed rail business is still an issue, and we are looking at kinds of beds available.

We are counting the things that are above the dots in the slide. Our discussion in this advisory group centered around two focuses. The first was that we decided to look at four stereotypes of patients that are commonly restrained. Joanne referred to these this morning. This was a way to get a handle on what we were doing with restraints.

As I said, this was a multi-disciplinary committee, and that was essential to solving the problems. For example, for the frail or unsafely mobile person, it is often the OT and PT people who have the resources to help us deal with that kind of problem. The whole team is needed to do this kind of problem solving.

We looked at alternate ways or suggestions for care planning for each of these groups and incorporated these suggestions into our video tape. We have two articles, one of which is included in one of the handouts today, which have case studies that illustrate some of these suggestions. I have a few copies of an article that was in "Nursing '89," called, "Avoiding Restraints: Why it Can Mean Good Practice." We used those words "good practice" to get them into the legal language. There are also case studies in that article that suggest other ways to approach these very difficult problems.

We talked about these four types of patients and also focused on those affected by a change away from restraint use. We concluded that they were, by and large, these four groups of people: the patient, the family, staff, and the institution. I am going to talk a little bit about each of those.

First of all, the patient. The patients react in a variety of ways to being restrained. A common reaction is that of protest, agitation, struggling to get out of restraints, and for those of us who have engaged in trying to restrain someone who is agitated, we know how much time that involves. I encourage those of you who are doing staff time counts to take that factor into account. Incidentally, we have not increased our staffing or changed our staffing in any way based on nonrestraint use.

Patients often react by protesting, but they may also react passively, by withdrawing. We are all familiar with the picture of rows of people sitting in wheelchairs with heads hanging down on their chests.

In general in our society, we restrain only two groups of people; one is children and the other is prisoners. I think we have to ask ourselves why we believe it is okay to restrain the old, the frail, or the ill.

There is also a question of paternalism versus personal autonomy. The issue of risk is not an easy one to come to grips with, but it has to be faced. We found that it helped for us to ask ourselves the question: how would it be if it were me who was choosing between risk or restraint? That is a very helpful perspective.

We must also consider what happens to other people's perception of a patient when he is restrained. There is no doubt that when a patient is restrained, he is more likely to be viewed by others pass-ing by as unsafe, as disturbed, as dangerous, or certainly as less competent. We have to remember the role of self-fulfilling prophecy in behavior.

Second, the family may react in many ways, but these often include, first of all, rejecting the idea of restraint. They often have feelings of horror and sadness at seeing their own mother or father restrained. But eventually, people generally come around to the view that the professional knows best. We can talk people into a wide variety of things that they must wonder about afterwards.

If they have been especially concerned about safety at home, then they may somehow see it as home being where it was unsafe and the hospital is where you must be safe at all costs. Therefore, we can generally talk people into agreeing with restraint use based on that premise. Occasionally, families may even request restraints for safety, but the request is more often that other people be tied who are disturbing their family member.

Our experience has been, generally, that families want what is best for their relative. Once they understand our rehabilitation process and our goals that acknowledge a person's dignity, they are generally pretty comfortable with the decision not to restrain.

Third, we looked at staff. Staff very definitely feel a tension between responsibility and blame, the tension between ensuring patient safety and encouraging autonomy for patients. There is no doubt that this produces anxiety for staff. We need to acknowledge that in making this kind of change.

Staff fear very much being blamed, particularly for accidents such as falls. We need to look at our incident reports. How do we force staff to report falls? Are the incident reports a red flag and are they logged on the person's professional record, and so on? I have seen examples of this, and it would be very difficult for those people to get past the feeling of blame if that is indeed how the administration works.

We found that staff need very much the support of head nurses, the heads of other disciplines, and especially physicians. We have made a very verbal and oft repeated pact that responsibility for the decisionmaking is shared by the whole team at case conference and is reviewed there.

Incidentally, I get a lot of credit for this change having taken place. It is our front-line nursing staff who own the credit for this. It has been their creativity that has enabled this process to happen.

Fourth, we had to look at the institution itself, at the tension between maintaining its reputation as a humane provider of care and its very real concern for the legal liabilities. Interestingly enough, our hospital lawyers found that there has never been a case in Canada where an institution has ever been found liable for not having used restraints. All suits were for misuse, which in turn, led to accidents. That was very important information for us.

In Canada, we also suffer from myths of what happens south of the border. They say, "The United States has all that litigation. It's going to flow over the border." So it was very reassuring to hear that this is indeed also the scenario in the United States.

Our lawyers found something else, though. Not only had an institution never been held liable for not having used restraints, but also, that in using restraints, we are liable for charges of assault and false imprisonment if we use restraints without the patient's consent. Mostly, restraints are used without patient consent. That was incredibly important information for us and very supportive to us in making this change.

We focused on those two issues, the four common groups of patients often restrained, and second, who was affected by the change. What happened then as a result of our discussions? We looked at numbers of restraints used before and after, and we have maintained this data to this day and at the number of falls, both serious and nonserious. I will explain that in a moment. Third, we looked at how many psychotropic drugs were used. As folks said this morning, we want to be sure that we are not just slugging people out on medications if we are not tying them up.

First of all then: how many restraints? The chart shows that the change occurred in late 1981 and early 1982. You can see that we still have an occasional use of a restraint. I always consider these a personal failure of my own creativity somehow.

I can tell you some examples, if you like, of problems that we were not able to solve. That last figure represents one person who was restrained for a period of 10 days, a woman who was exceedingly demented and had psoriasis on her face which she would not quit clawing at, so we put a mitt on her. I consider that a problem of my own creativity. I was not able to think of a way around that. It is incredibly challenging to get past these, but at some time we will.

Second is the number of falls per 1,000 patient days. A serious fall is defined as any fall that requires a doctor to do something more than just examine the patient. Anything from one stitch in the finger to a broken hip is considered a serious fall, and we have not had any statistically significant increase in serious falls. There have been ups and downs in numbers of falls, and this past year we have had an increase which we are now examining very carefully.

Third, our psychotropic drug use—you notice that between the years of 1982 and 1983, with 1982 being the first full year of limited restraint use, we had a 29 percent reduction in the numbers of doses of psychotropic drugs. We can only speculate about that, but we assume it is because we did more careful care planning after that time. We certainly were not slugging people out on medications.

Incidentally, those of you who are administrators will be interested in this. Our Central Supply Department which supplies our restraints, estimates a savings of $15,000 in the first 2 years due to less replacing, distributing, and laundering of restraints.

What are we doing now? We now regard the use of restraints as a negative practice. The next slide shows a patient restrained in Bedlam in 1815. As Neville Strumpf said this morning, the arguments against freeing the folks from Bedlam are the same as the arguments we are hearing now. We need to look more at the hazards and problems of using restraints, problems with mobility, incontinence, skin breakdown, etc.

At present, we rarely consider the use of restraints. We consider them to be an unusual response to an unusual situation. We regard nonrestraint as progressive practice and we feel that we are able to care safely for a broad range of elderly people without using physical restraints.

Thank you for asking me to be here today.

STATEMENT OF CARTER CATLETT WILLIAMS

Ms. WILLIAMS. What I will be speaking to you about for a few minutes is a visit to a nursing home in Goteborg, Sweden, called Gråbergets. I visited several times and talked with the Administrator and Director of Nursing, Ulla Turemark. It is a nursing home that has 210 people in residence, basically of the same functional level as people in our skilled nursing facilities and with a staffing ratio, so far as I could tell, roughly similar to that of our better-staffed homes.

I had heard Lynne Mitchell-Pedersen's paper 4 years ago in New York, but the first time I had a chance to observe restraint-free care was at Goteborg. I sat on the edge of my chair as I asked Ulla, "How do you do it without using restraints? How do you care for people who are so sick?"

Her answer was very low-key. She said, "It is attention to many details. There is no one magic formula. The concept that we deal with here is individualized care." As she talked to me and I observed, I saw that it was a person-oriented care rather than a task-oriented care. You will see many common themes as I run through the elements that I saw there.

There were six elements. They had to do with continuity of relationship, with opportunities for residents to make choices, with comfort and safety, attention to homelike surroundings, attention to staff attitude and morale, and a special approach to people with dementia.

The matter of continuity of relationship they took very seriously, and once a person entered the home, he/she stayed with the same staff. From this knowledge that the nursing staff, particularly, had of the patient, flowed the ability to develop an individualized care plan with that resident and his or her family. That was basic to the whole process.

Nurses were responsible for knowing the needs and preferences and the customary daily patterns of people who were admitted to the home so that they could bring flexibility into their lives in the nursing home, insofar as possible. That leads us to the second element, which is choice.

Ulla said to me, "Everyone at this home awakens of his or her own accord in the morning." There is no uniform routing of people out of bed at an early hour as happens in many of our homes. There is an element of comfort and of recognition that we all have different schedules and rhythms to our days. There is choice about food. For anyone who can feed himself, meals are served family-style.

There are choices by residents of what clothes they want to wear and choices about activity and refinement of activity patterns so that attention is paid to the little things that a person does each day. It is not thought of so much in terms of group activity.

There is emphasis on comfort and safety. One of the prime examples is that as soon as a person is admitted to the nursing home, the occupational therapist works with that individual to find the most comfortable chair for him/her and to work out the arrangement of pillows, bolsters, and so forth that achieve good positioning. You see people sitting in many different kinds of chairs. There are beds that lower to within 16 inches of the floor. So that injuries associated with getting in and out of bed, or falling out of bed, are minimized.

Fourth, there is a lot of attention given to a homelike atmosphere and homelike surroundings. Residents bring furniture to the common rooms as well as to their own rooms. You see upholstered chairs, rocking chairs, rocking stools, sideboards, afghans, and different lighting fixtures. What I notice with much satisfaction was that this adds to the individuality of the person with dementia and his or her personhood, because such a person needs all the clues possible that say, "I am a socially functioning human being." If I am sitting beside the coffee table and there are flowers and a cloth on the table and a picture above me, and I am sitting in a homelike, non-institutional kind of chair, it helps me and the staff to see me as an individual person.

There is attention to staff attitude and morale, and constant education. The thrust of the education is that sick older people are people like the rest of us. There is emphasis on the fact that we are perpetual students. At Gråbergets they do not feel that they have arrived at a final body of knowledge. They are constantly evolving and finding new ways to individualize care.

Finally, there is a special approach to patients with dementia. That approach is based on the conviction that people with Alzheimer's and other dementing diseases have feelings, have preferences and needs which we, in large measure, can learn to understand. We have heard Joanne Rader and others refer to this here today.

We can begin to understand and we can respond on an individual basis. We can learn what is upsetting to an individual and what is comforting and learn the ways that we can reach people without tying them down.

A different kind of place results when you are doing this kind of care: calmness, contentment, and respect for the individual person mark this place. Once you have seen it, you have to bear witness to it.

Thank you.

Dr. Torell. We will have an opportunity later in the program to bring the panel back up here for questions. In the meantime, I would like to thank the four of you for your comments.

Mr. Lewis. Our next presenters are in the area of New Federal Policy Directives. Sarah Burger is a consultant for the National Citizens' Coalition for Nursing Home Reform. She is author of "The Ombudsman Guide to Effective Advocacy Regarding Appropriate Use of Chemical and Physical Restraints." Sarah will introduce our two speakers in this area.

Sarah.

STATEMENT OF SARAH BURGER

Ms. Burger. Thank you very much.

For the last hour or so, you have been listening to the nuts and bolts of how to do it. We are going to take you to a different plane now and find out what will help us do it. Eliminating inappropriate physical and chemical restraints is a surrogate, really, for the quality of care and quality of life of all residents in nursing homes, each and every one of them. Finding alternative methods of care for the restrained population requires the same process as determining the care for all residents in nursing homes.

Physical restraints are really an observable red flag. They tell us that, that person's needs are not being either defined or met. We cannot unlock restraints without individualized assessment of both strengths and needs and also individualized care planning and implementation. This process to eliminate inappropriate restraint use is the same process that should be used to provide quality of care and quality of life for all residents in nursing homes.

The Nursing Home Reform Act of 1987—we refer to it as OBRA—provides a mandate for quality of care and quality of life. It also tells us about residents' rights, specific to chemical and physical abuse, resident assessment, and care planning. It also speaks to the delivery of services.

Let me just highlight a few little places in that law for you. You have a copy of it in your packet of materials.

A nursing facility must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life for each resident in accordance with a written plan of care. That plan of care should be made up with the resident and/or the resident's family or legal representative present at the care planning conference. That is written right into the law, and I think that this morning, Jill spoke to that beautifully when she said that the resident must be the one who gives permission to use or not use restraints.

A nursing facility must provide services to attain and maintain the highest practicable mental, physical, and psycho-social well-being of each resident. A nursing facility must promote and protect the rights of each resident, including the right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any of the physical and chemical restraints imposed for purposes of discipline or convenience and not required to treat the patient's or resident's medical symptoms.

In addition to the health care financing activities, which we will be hearing about in a minute, to implement OBRA, changes in the Older Americans Act in 1987 strengthened the long-term care ombudsman programs, which as an advocate for nursing home residents, has greater authority now to implement OBRA and see that its highest standards are met. The Health Care Financing Administration has demonstrated great sensitivity and leadership in carrying out the OBRA mandate by issuing regulations and interpretive guidelines designed to promote individualized assessment and care, the basis for increasing the quality of care and quality of life for nursing home residents and decreasing inappropriate restraint use. Our two speakers will speak more to that.

It gives me great pleasure to introduce our first speaker, Alan Friedlob, who is the Chief of the Nursing Homes Branch, the Office of Licensing and Certification in the Health Care Financing Administration. He is a Commander in the U.S. Public Health Service, but most of all, I want to tell you that he has been a wonderful listener, a very careful listener, to all sides of the concerns on this issue. As such, he has been able to write regulations and requirements and instruction and training for surveyors that really have been extremely sensitive. It is a pleasure to introduce you to Alan Friedlob.

STATEMENT OF ALAN FRIEDLOB

Mr. **Friedlob**. Thank you. I am glad to be here representing the Health Care Financing Administration.

The Nursing Homes Branch has been responsible for writing the interpretive guidelines and developing the survey procedures to support regulation of the quality of care of nursing facilities. It is from that perspective that my remarks will focus on discussing the new long-term care requirements and interpretive guidelines as they apply to assessing the use of physical restraints.

First, I want to show how the language of these regulations relates to public policy concerns about the use of restraints in nursing facilities. Second, I want to examine how monitoring the use of physical restraints is addressed in other areas of the regulatory process, in particular, the OBRA 1987 mandated resident assessment initiative, and monitoring the effects of a nursing facilities environment on the quality of life of residents. Finally, I will comment on how HCFA will monitor the effects of these new regulatory requirements and survey procedures on restraint use.

The nursing facility requirement concerning restraint use states that a resident has the right to be free from any physical restraints imposed or psychoactive drug administered for purposes of discipline or convenience and not required to treat the resident's medical symptoms. In developing the interpretive guideline to assist State and Federal surveyors in evaluating a facility's use of physical restraints, we consulted widely with industry representatives, resident advocates, and professional groups. Many of you are in the audience today, and we wish to take the opportunity to thank you for your cooperative efforts.

These consultative activities focused on two issues: what constitutes a restraint and under what circumstances can a restraint be used? We approached resolving these issues by keeping in mind a principal policy objective of OBRA 1987, "That each resident must receive and the facility must provide the necessary care and services to attain and maintain the highest practicable physical or mental and psycho-social well-being in accordance with the comprehensive assessment and plan of care."

Thus, in reviewing the use of restraints, we ask that surveyors not only assure that restraints do not harm a resident's well-being, but that if used, these devices enhance that resident's well-being. In the interpretive guideline, physical restraints are defined as, "Any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual can not remove easily, which restricts freedom of movement or normal access to one's body."

Leg restraints, hand mitts, soft ties or vests, wheelchair safety bars, and Geri-chairs are included in this definition. Bed rails have not been included in this list of physical restraints, but are addressed explicitly in the interpretive guideline concerning accident hazards, "Misuse of bed rails," that is, to keep someone from getting out of bed voluntarily.

Regarding the circumstances under which physical restraints may be used, the requirement rejects the use of restraints as a means of coping with staff shortages, that is, "for purposes of convenience," or managing resident behavior in the absence of a comprehensive assessment of a resident's needs, that is, "for purposes of discipline."

Rather, surveyors are directed to examine the appropriateness of the clinical objectives for which the restraint is used. For example, we recieved many comments that physical restraints such as vests are used routinely for purposes of postural support, even though in this regard, they may be of questionable effectiveness.

Thus, the guideline states that, "Less restrictive measures than restraints, such as pillows, pads, removable lap trays, coupled with appropriate exercise, are often effective in achieving proper body position, balance, alignment, and preventing contractures." We ask that surveyors look to see if and how the facility has sought to use less-restrictive supportive devices prior to using physical restraints as defined in this guideline.

Furthermore, the interpretive guideline states that if the facility's staff decides that the physical restraint would "enable and promote greater functional independence, then the use of the restraining device must first be explained to the resident, family member, or legal representative, and if the resident, family member, or legal representative agrees to this treatment alternative, then the restraining device may be used for the specified periods for which the restraint has been determined to be an enabler." The interpretation of this regulatory requirement asks facilities, in consultation with the resident and family, to weigh explicitly the risks and benefits of using restraints.

For example, what process has the facility used to evaluate the resident's desire to maintain his or her dignity by avoiding use of a restraint, even though he or she will be at greater risk of falls, or conversely, the resident's desire to avoid falls through use of a restraint after alternatives have been documented?

Additionally, restraint use may be determined by a physician to be necessary in situations where there are medical symptoms which are life-threatening, such as dehydration, electrolyte imbalance, or urinary blockage, and use of the restraint is temporary and enables treatment. For example, the time-limited use of hand mitts may be justified to restrain a resident readmitted from the hospital with a urinary catheter until the resident has recovered sufficiently to initiate bladder retraining.

In addition to commenting on the nursing facility requirement interpretive guideline, I also want to briefly discuss the relationship between the monitoring of restraint use and other components of OBRA 1987. Beginning October 1, 1990, OBRA 1987 requires that all nursing facility providers administer a comprehensive resident assessment based on a nationally uniform minimum data set. Not only is it the intent of the OBRA 1987 resident assessment initiative to improve the quality of assessment and care planning in nursing facilities, but we want resident assessment to serve as the cornerstone of the outcome-oriented survey process.

We want to direct surveyors to review the use of restraints from an outcome-oriented perspective. That is, monitoring the effects of restraint use on resident's psycho-social and physical functioning. Once the minimum data set and resident assessment instrument is in place, surveyors will be able to examine consistently the association between the use of restraints and negative resident outcomes, such as chronic constipation, incontinence, pressure sores, loss of independent mobility, increased agitation, or symptoms of withdrawal or depression.

We will be able to better examine the possibility that failure to provide aggressive competent rehabilitation and other care over time leads to the inevitable use of restraints. Our goal is to get surveyors to use resident assessment as the means for holistically reviewing the impact of facility care and treatment practices on the resident.

This orientation is meant to minimize, for example, the review of the use of physical restraints in isolation, with minimal consideration of how restraints affect the health and quality of life outcomes, given the unique needs of each resident, and vice versa, how care provided affects the use of restraints. This is the way for a facility to eventually have an environment in which the use of restraints is minimal.

The new long-term care requirements and interpretive guidelines also ask surveyors to review the characteristics of a facility's physical environment that promote maximum independence and self-control. For example, in the quality of life requirement for accommodation of needs, the interpretive guideline addresses, "* * * Adaptations of the facility's physical environment that aid residents to maintain unassisted function. For example, measures to safeguard cognitively impaired residents who wander from undue danger, yet allowing them to walk around unrestrained."

We thus have the challenge of training surveyors to make them more aware of how the facility's environment can be adapted to promote safe wandering behavior so as to reduce the use of physical restraints and minimize the risk of serious injury due to falls. We want to ensure that surveyors look for how facilities are attempting to accommodate the disparate needs of residents in ways that may obviate the routine use of physical restraints.

In conclusion, the new requirements and interpretive guidelines have set a clear expectation that providers will exhaust alternative methods before applying restraints and will assure that when restraints are applied, resident rights, health, and safety, are protected. We do not require nursing facilities to become restraint-free upon implementation of these requirements, but we are certainly supportive and wish to facilitate providers' efforts to reduce or eliminate the use of physical restraints.

In our ongoing monitoring efforts, we need to know more about the organizational and resident characteristics that distinguish high restraint-using facilities. During the course of developing these regulations, the following research issues emerged that may affect facilities' ability to formulate interventions and reduce the use of restraints.

What happens to nursing staff who have relied on restraints and who are asked to change customary behavior? What roles do families and physicians play in influencing changes in facility policies about restraint use? How can changes in environmental design affect restraint use? How do existing codes limit facilities' ability to respond creatively to find environmental solutions to restraint use? What are the costs associated with providing a restraint-free environment; of low restraint use; of above average restraint use? What are the costs of individualizing care?

What are the accident and injury rates due to high versus low restraint use? How do the attitudes of nursing facility administrators and boards of trustees toward litigation and negligence affect restraint use policies? How do staff and resident attitudes toward resident autonomy, risk-taking, and choice influence restraint use?

What is the interaction between use of physical restraints and psychoactive drugs for managing resident behavior inappropriately? Will regulatory policies monitoring the use of physical restraints lead to increased use of psychoactive medications for such purposes? Finally, through the resident assessment system, can we validly and reliably measure the adverse physiological and psychological effects of prolonged restraint use?

I want to thank the Senate Committee for giving HCFA the opportunity to comment.

Ms. **Burger**. Thank you very much, Alan.

Our second speaker is Connie Cheren, who is Director of Licensure and Certification for the Health and Human Rehabilitative Services, State of Florida. I like the fact that they have rehabilitative right in there in the title of their agency. That is nice.

She is responsible for licensing and certification of over 4,300 health care facilities, including 27 different types of providers. Nursing homes and hospitals both come under her purview.

She is a registered nurse and also an M.S.W. and her past experience includes development and implementation of the Illinois QUIP program, which is the Quality Incentive Program that some of you are probably familiar with. At the same time, she redesigned the Illinois reimbursement program into one which focuses on providing restorative care, a basic tenet for successful restraint removal.

Connie was a nurse in a long-term care pediatric Medicaid skilled-care facility for a number of years. This was for profoundly and severely mentally retarded children. She says that it was there that she first realized that institutions could give quality care.

We look forward to hearing from you, Connie.

STATEMENT OF CONNIE CHEREN

Ms. **Cheren**. Thank you, Sarah.

I am glad to be here today from Florida to share the good news that is happening in Florida, to share what has happened in Florida over the past several months in response to what we are calling restraint reduction. I think that the success of this is shared by many people. Mostly it is because of the provider response. That is what I want to share with you today.

It is also in response to regulation. As a regulator, I take responsibility very seriously, and what I have learned over the past several months is that the bottom line is that regulation works. In this area, I certainly don't think we need any more regulation—I think we need to read the regulation that we have and enforce the regulation in this country. I think that the dramatic results that you can see that have happened in Florida over the past several months makes me a believer again in good, fair, aggressive—I like to use that word aggressive—enforcement.

The St. Petersburg Times also deserves much credit in keeping this issue in the forefront over the past several years. They were the newspaper that highlighted the several deaths that occurred in Florida and throughout the country. We had five deaths from the inappropriate use of restraints in the State of Florida.

When I became director there a little over 2 years ago, Steve Nohlgren of the "St. Petersburg Times" started following the kind of work that I wanted to do in Florida. I was in a facility at that time and toured the facility, and there was a resident restrained. You can always tell when a resident who is restrained can walk. You can tell because they seem to be ready to stand up and you know that if the restraint is released, they can stand.

I said to the staff there, "Why is this person restrained?" They gave the response, "Because he'll walk and we won't know where he goes." I just gave a seminar to providers and I said, "If you are going to inappropriately use restraints, for God's sake, don't tell the director of the agency that you are restraining people to keep them from ambulating, and that you don't have staff to watch them. You might as well write your own deficiency if you are going to do that."

We did tell them that day that they had to release that resident; that they could not do that. Steve wrote that in an article and the providers saw that. Then Steve asked me, "What are you going to do about restraints in Florida?" I said, "We are going to reduce restraints." We were at that time at about 41 percent, and that is right in keeping with what the national average was, which I think is extremely high. So I said, "We are going to reduce that number."

We have been focusing on restorative programs and other kinds of things. This summer, there was a knock on the door and Steve essentially said, "Connie, what is the restraint use in Florida?" I said I didn't know and, "Let me get the MMAC data, the self-reporting tool that the providers do each year at annual survey time and it is the only data that we really have that we can rely on at this point. It came out to be 49 percent.

I said, "Steve, let's talk about this." The MMAC material had changed in the interim and I wasn't so sure that it was reliable. I said, "If it is that high, that is very distressing, but let me do some review of that, and let's do a survey of the providers and see where we really are." Well, I do frequent visits in nursing homes—very frequent.

My favorite part of my job is to go out and to be with residents, to tour facilities, and to see what is going on. I think that is the best outcome of how we are doing, to actually see what is happening.

That following week I was in a facility and it happened to be in Tampa in the St. Petersburg Times area. Sure enough, there were residents who were inappropriately restrained.

I asked the same question, "Why is this resident restrained?" They said, "Because he will ambulate," and now we were almost 2 years later and we still had providers saying to us, "Because he will ambulate."

Every surveyor that is in a facility is weighing information on at which point are you going to cite a deficiency. I saw a resident walking down the hallway with her restraint flapping behind her, and I knew right then. Something just outraged me, and outrage was a good word.

We have, thank goodness, authority to place a moratorium on a facility at any time, which means that they can not admit either private or Medicaid residents. I said, "This facility is officially under moratorium as of today."

Well, they had the owner of the facility in the place within 10 minutes and they said, "Can we have a chance for correction?" I really did think about it and I said, "No, you've had time and this is not appropriate. We've been saying this for 2 years, so you are officially under a moratorium."

The response was that it sent shock waves among the providers. It was the first time that we took that kind of an aggressive stand to say that inappropriate use of restraints was not acceptable.

The provider association responded by setting up three seminars. Jill came to Florida and has been a big help to us. We had over 1,000 providers attend the three seminars to learn about restraint reduction.

Since then, we did a survey just 2 months ago to see where we are with restraints because the stories are very dramatic. We are at 37 percent right now and we are going to do that survey again in January. We estimate that over 3,000 nursing home residents have been released from restraints in the past 4 months.

Individual facility highlights are very dramatic. We have six facility statistics today, with one facility that had 44 percent and is now down to 15 percent. They had 53 residents restrained and reduced that number to 18. We have a 450-bed nursing home that had 117 residents restrained in August. Today, they have 20 residents that are restrained, a reduction of 97 residents.

There seems to be a contest now to see who is going to be the first restraint-free facility. We are working very carefully with them in the process of reducing the restraints.

It is a very interesting story about the placement of that moratorium. We have copies for those who are interested of Steve Nohlgren's recent story. He still writes about what we are doing.

He went back and interviewed that facility and they said, "She sure rattled our cage that day, but it is right," and they have reduced the restraints. When I placed the moratorium they said, "If we untie that man you are talking about, he is going to take a walk," and I said, "Great, plan for it. Go out with him and go for a walk with him."

Since then, they set up a buddy system so that all the housekeepers and even the office staff are assigned to a resident, and every day they take that resident outside for a walk. They said now the residents are coming to get the staff and saying, "It's time for us to go outside and take a walk."

How we are continuing to address this as a regulatory agency—it's the first thing since the Illinois Quality Incentive Program, where we said that if you have living things in the facility other than the staff and patients, i.e., fish tanks, and every nursing home in Illinois got a fish tank—this is the first time that I have seen a response to something as dramatic as this.

We, as a regulatory agency, quite honestly, are trying to keep up with the providers at this point. The really are the ones who have taken the lead now in becoming restraint-free.

In response to looking at what they are doing, we are reemphasizing restorative care. It is correct to say that restraint is only the tail end of the issue that is an example of poor care. It goes back to what has been in the regulations since 1965. God forbid that anyone will leave here today and think that because OBRA has been postponed for implementation—Well, I called into my office on break this morning and they said that they had a call from a provider who wanted to know, "Since OBRA has been postponed, is the restraint reduction program postponed?"

OBRA does not invent the idea of appropriate use of restraints. It only reemphasizes and rewords some of that. It is in the current regulations and it is also in most State licensing regulations. It is doing a good assessment; it is setting up a good restorative program that focuses on independence, not dependence, that focuses on possibilities, not limitations, that works creatively and aggressively to help residents function at the highest level possible.

When all of this is done and a care plan is developed with goals and approaches that are implemented with the input of the resident and the family, we will find that restraints are not necessary; where residents learn how to continue to eat where there are restorative eating programs so that N/G tubes are not necessary, so that people who walk into nursing homes can walk after 6 months and we won't need postural devices. Those are all the product of a lack of good assessments and a lack of an aggressive restorative program.

We must begin to focus regulation, not on just the presence of negative outcomes like bed sores, restraints, and contractures, but we must also focus on the absence of good care, the absence of good, positive outcomes. That is a bold step for us to take in this country because that means that we then have expectations that, yes, old people can get better; they can learn to eat again, and they can learn to walk again. We don't have a right as caregivers, as regulators, as providers, to make that decision for someone anyway. We only have the responsibility to ensure that the setting is in place for that person to have that opportunity.

The other thing that we are encouraging facilities to do is to include occupational therapy, physical therapy, and recreational therapy in the overall plan. In the absence of those things, just removing restraints will not be the answer.

The second thing is honesty and trust in developing—I am a little fearful when I hear the word creative. I applaud all the creative opportunities and alternatives to restraints, but I hope that people continue to remember that these people are people just like you and I in that anything that is dishonest in an approach to fool them—well, we don't know what they know. We don't really know what they know and what they don't know, and if that trust is broken between a resident and a caregiver, I think it is going to be very damaging.

The last thing is to treat people like adults. These are people who are adults, not children. We must be careful in all of our approaches that there are adult alternatives, exercises like you and I do, the kinds of things that look very much like adults.

In conclusion, we are continuing the call for good assessments and good restorative care. As you can see by these results, it can work.

Thank you for the opportuntity to be here.

Ms. **BURGER**. Clearly, we have a new standard of care today that has been expressed well by Alan speaking at the Federal level, and by Connie at the State level, which is inspiring to all of us.

Thank you both very much.

Mr. **LEWIS**. Thank you very much for those presentations.

We are going to take a break now for about 10 minutes. I also want to mention that at around 4 o'clock, we expect to have copies of Alan Hunt's legal materials available for you in the back. If you want to, you can get them after that time.[*]

See you back here in 10 minutes. Thank you.

[Recess.]

Mr. **LEWIS**. Our next session is entitled, "Looking Ahead: Changing Practice Through Training, Education and Research." To lead this discussion, we have T. Franklin Williams. Dr. Williams is Director of the National Institute on Aging and is internationally respected for his research in clinical problems of older adults. He has been an advocate for implementation of research findings in practice and for individualized care for institutionalized older people.

It gives me great pleasure today to welcome Frank Williams.

STATEMENT OF DR. T. FRANKLIN WILLIAMS

Dr. **WILLIAMS**. Thank you very much, Lloyd. it is certainly impressive to see the interest in this session and to see the quite imaginative and committed involvement that is being expressed here by so many people.

This session, as Lloyd said, is focusing on looking ahead and changing practice through training, education, and research. We have a series of people who will be speaking on different aspects of this from their own points of view.

First is Anne Morris, who is Gerontology Program Manager for the American Occupational Therapy Association. Her areas of expertise are environmental modification and the promotion of functional independence for older people.

Anne?

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[*] See appendix 2, p. 197.

STATEMENT OF ANNE MORRIS

Ms. **Morris**. I am certainly very happy to be with you this afternoon representing the 42,000 occupational therapists around the United States. The topic I will be addressing is "Occupation as Interaction with the Environment." I wish to clarify the importance of fostering resident interaction within one's surroundings, rather than eliminating it through restraint use.

In order to create caring environments, an occupational therapist finds it most helpful to explore all aspects of a residents environment. These are best identified by referring to the model of human occupation first proposed by Kielhofner and Burke in 1980 and later expanded by Barris in 1983. The model offers particularly helpful information to all members of the nursing home community because it identifies several concepts that help explain the occupational nature of human beings. Through training and education, residents, staff, administration, family, and friends can learn to recognize the benefits of and necessity for developing regenerative and caring communities within the nursing home setting.[1]

Across the life span, human beings have a need to explore and master their surroundings which leads them to pursue activity. Such exploration involves the use of all sensory systems, sight, sound, touch, taste, smell, and most importantly, the freedom to move about at will in a surrounding of choice. Occupational behavior—that is, the self-care, play, and work tasks of our daily life—is activity which helps define for each of us our personal existence. Personal needs are satisfied and successfully or inadequately met through the opportunity to participate in daily activities.[2]

When dysfunction exists as seen in behaviors characteristic of the confused elderly such as agitated behavior or frequency of falling, the concern by the familly and staff for that individual needs to be in terms of how these deficits impact upon his or her ability to participate in daily activities. Attention must be directed toward the entire person. Enablement of either direct or indirect participation in activity needs to be initiated.[3]

In the model of human occupation, the human being is represented as an "open system" who chooses to interact within the various daily surroundings. In the model, the environment is conceptualized as four concentric circles or layers surrounding the persons. The innermost circle contains objects which are things that we each use to perform a task. The second circle includes the tasks, those activities of daily living which each of us perform: self-care, play, and work. The third circle represents the social groups and organizations with whom we come into contact: nursing home staff and administration, work teams, family members, and friends. The outermost circle, of course, includes culture, representing the values and beliefs binding and determining individual and group pursuits.

As mobility and energy decrease, the frail elderly person's environment usually becomes much smaller. Increasing amounts of time are spent sitting, less movement occurs in a typical day.

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[1] Porszt. Miron, 1988; Hersch, 1989; Calnon, 1989; Kari & Michels, 1989.

[2] Barris el al, 1985.

[3] Macdonald, 1986; Sincox and Cohen, 1986; Zgola, 1987; Rogers, 1989.

Social contacts dwindle, further limiting interaction with the environment. In essence, the environment no longer provides an easily accessible arena for practicing performance skills or maintaining roles, and certainly reduces positive reinforcement of self-esteem. "Environmental press" those demands which exceed or offer inadequate challenge for the patient's capabilities lead to maladaptive performance, and affect.[4]

Opportunities to use relaxation skills to reduce stress is often difficult to provide for the frail elderly resident. Research studies continue to verify the importance of movement in space as a means for relaxation. Use of the rocking chair has long been a popular choice for relaxation for this reason.[5]

At a North Carolina Convalescent Center studies have been conducted using the "Carolina Rocker", a platform which is secured to the base of a regular wheelchair. Results show that the non-ambulatory, wheelchair-mobile resident can benefit from the effects of rocking.[6]

The frail elder person typically displays combinations of mobility, congnitive and emotional impairments. Anatomical and physiological changes begin to impinge upon postural requirements, seating comfort and performance of functional activities. "Clients who well positioned will increase their participation in and functional performance of important self-care skills. Interaction with the environment, awareness, and communication with peers and staff will increase." [7] "Postural intervention is especially important for those patients who do not have adequate musculoskeletal, proprioceptive, or cognitive ability to readjust their position." [8]

In 1989 RESNA press published the report from a State-of-the-Art Conference, held in Charlottesville, VA on December 14 and 15, 1989, and sponsored by the Inter-agency Group on Aging. Experts in attendance at the Conference identified critical needs for additional research about seating and mobility needs for the cognitively impaired elderly in the areas of: sitting, transfers, walking, and wheeled mobility. Statistics indicate that 820,000 cognitively impaired persons are part of 6 million frail elderly persons in the United States. At that meeting an occupational therapist, Alexandra Enders, proposed adaptation of a conceptual model describing the utilization of technology currently available. She identifies the existence of a tremendous gap both in the availability and the utilization of assistive technology to enhance environments for the cognitively impaired frail elderly population. (See figures 1 and 2; Brubaker, 1989).

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[4] Lawton, 1982, Rogers, 1989.

[5] Van Dusen & Kiernat, 1986; Houston, 1989.

[6] Bailey, 1989.

[7] Epstein & Sadownick, 1989.

[8] Plautz & Timen, 1989.

A Conceptual Model of the Availability of Powered Mobility Devices to Disabled Individuals with respect to Age and Severity of Disability

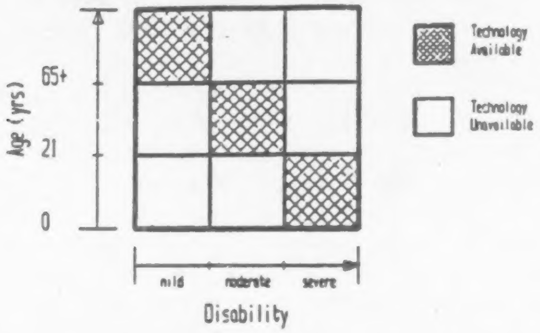
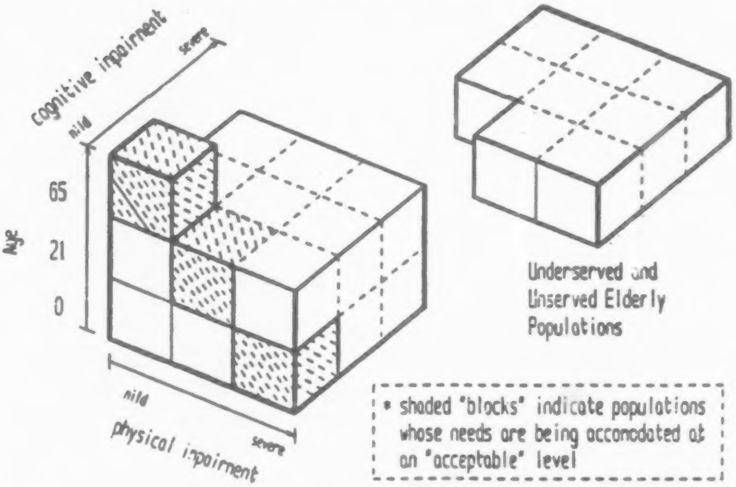

Age (yrs)
65+
21
0
mild
moderate
severe
Disability
Technology Available
Technology Unavailable

Fig. 1. Enders Model of technology availability: A. Enders, Service Delivery and Distribution Issues, WHEELCHAIR IV - A State-of-the-Art Conference on Powered Mobility, sponsored by UVA-REC and NIDRR, December 7-9, 1988, Charlottesville, Virginia.

A Conceptual Model of the Availability and Utilization of Assistive Technology to meet the Seating and Mobility Needs of Physically and Cognitively Impaired Populations with respect to Age and Severity of Impairment


cognitive impairment
mild
severe
Age
65
21
0
mild
physical impairment
severe
Underserved and Unserved Elderly Populations

* shaded "blocks" indicate populations whose needs are being accomodated at an "acceptable" level

Fig. 2. A 3-Dimensional Adaptation of the Enders Model (Fig. 1.) to show availability of technology to the cognitively impaired

Brubaker, CE (ed)(1989). The Availability and Utilization of Assistive Technology to Meet the Seating and Mobility Needs of Severely Disabled and Elderly Persons: A Report of a State-of-the-Art Conference. December 14-15, 1988. Washington, DC: RESNA Press.

Ms. **Morris**. Occupational therapy, then, is unique in the way that we view the frail elderly nursing home resident exhibiting at-risk behaviors. Application of this human occupation model is reflected in suggestions made by Wendy Wood, an occupational therapy educator at the University of Pittsburgh.

Looking at one type of patient who is typically restrained, the person at risk for falls, she proposed these techniques for creating user friendly environments: "* * * adequate illumination, railings mounted on walls, level thresholds between rooms, removal of clutter, visual highlighting of door frames and bathroom entrances, availability of chairs as the resident walks down the very long hallways, availability of appropriate bathroom equipment, stable chairs in the bedroom and bath to be used during personal care, and availability of the opportunity to perform daily living activities which serve to maintain flexibility, endurance, coordination, and self-efficacy."

Interventions suggested for those at risk for falling includes: "training with appropriate assistive devices, analysis of activity tolerance over the course of the day, with more assistance provided when activity tolerance is poorest, individualized exercise programs to improve endurance, logging of those circumstances surrounding falls with tailored interventions for preventing more falls, daily habit training regarding safe management of orthostatic hypertension, and frequent and routine periods of supervised ambulation in order to maintain mobility and endurance." [9]

Restraints are frequently used with residents who demonstrate agitated behaviors. Affirming communications which lead to establishment of rapport with the agitated resident have been found to renew an interest in activities.[10]

Although independent pursuit of an activity may no longer be possible, the patient continues to maintain performance skills for certain aspects of that activity. Most importantly, the resident possesses those basic psychological needs common to each of us: a need to be productive, to know one's self as a valued person, and to maintain contact with his or her surroundings and with other people. Because occupation involves a complex interaction of biological, psychosocial, and environmental factors, family and staff need to know and to learn how to adapt the task to the patient's remaining abilities.[11]

In 1980, at a University of California conference called "Environments for Humanized Health Care," Barry Barken, then Director of the Live Oak Institute, presented a paper describing the concept of the Live Oak Regenerative Community. He said, "We can not talk about creating a genuinely alternative environment for the infirm aging without creating a culture which not only will be healing for the elders who live and die there, but will also be healing for everyone who interacts within that environment."

That concept had considerable impact upon the development of the Lazarus Project, a collaborative research experience recently initiated by an occupational therapist, Nancy Kari and an historian, Peg Michels. They describe the Project as "* * * an interactive educational process intended to empower resident members, their families and staff * * *" through "* * * establishing the feasibility of an alternative community model for organizing service delivery within a nursing home setting * * * The concept of community in this particular project means more than a group of individuals sharing a common space. Interdependent groups of people learn to accept differences among members and to respond to each other with respect. Purposeful activity in the form of individual contribution is central to the development of that kind of community. Each member can participate in decisionmaking, has a role, and is accountable for its fulfillment. Acknowledgment is given to these contributions and legitimized. Dignity is thereby maintained. A resulting trust in the sense of community emerges and a lively regenerative environment is formed." [12]

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[9] Wood, 1989, p. 2.

[10] Porzst-Miron, 1989.

[11] Sincox, 1986; Zgola, 1987; Rogers, 1989; Wood, 1989.

The image created by the project's name captures the very essence of today's symposium. Reflecting on the Biblical source of the story about Lazarus we see him emerge from the cave with hands and feet bound in cloth. Those in attendance were asked to unbind him an let him free. If we think in terms of unbinding the elderly in nursing homes rather than restraining them, the opportunity to create a growth enhancing environment will be available for everyone—residents, staff, administration, family and friends—the entire nursing home community.

I hope that some of these occupational therapy perspectives reinforce the importance of fostering resident interaction with the environment rather than eliminating it through restraint use. A further hope is that each of you will strive to reinforce others' awareness of the urgency demanded for establishing restraint-free environments which allow growth and development to continue well into the later years.

Thank you.

Dr. WILLIAMS. Thank you very much, Ms. Morris. I think that the concept of resident interaction with the environment is very appealing.

We will next hear from Dr. L. Gregory Pawlson, who is President of the American Geriatrics Society. He is also Acting Chairman of the Department of Health Care Sciences at George Washington University Medical Center, and has been a leader in developing the geriatrics program at George Washington University.

His areas of interest and research include medical education, health policy, health services, and health care financing, especially as they relate to older people and geriatric medicine. He serves on the editorial boards of several medical journals and is Section Editor of the Law and Public Policy Section of The Journal of the American Geriatrics Society. He will speak about professional educational today.

Greg.

STATEMENT OF DR. L. GREGORY PAWLSON

Dr. PAWLSON. Thank you very much.

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[12] Kari & Michels, 1989, pp. 1-2.

I might say that I think you have already found a convert. I was very intrigued by the model that you were developing because I think that it reflects on what I am about to say. It is almost like we have the solution, perhaps before we have recognized the problem in medical education.

The first point I would like to make really echoes what you have heard before, but comes from a slightly different point of view. I think that from an academic or scientific perspective, the best that we can say about the use of chemical and physical restraints in the nursing home is that the indications for the use are unclear and that the evidence for the efficacy and safety of their use is essentially nonexistent. I will return to those briefly a little later. Dr. Lois Evans will speak about this area in more detail.

The main focus of what I would like to say today is less immediate, but I think that in the long run, it is important if we don't want to be back here in 6 months or a year or 2 with yet another issue like physical restraints. The real issue that confronts us is: how do we provide at a reasonable cost a safe, appropriate, and humane nursing care environment for a persons with both cognitive and physical impairments.

As a number of speakers today have very eloquently indicated, the use of personal restraints is clearly an inadequate answer for that problem. Their suggestion that we modify the environments of care rather than modifying the person is very simply and profound. Yet, what seems to be a very self-evident finding, presents a major challenge, I believe, to most traditionally trained health professionals.

That challenge really brings me to the major point of my presentation. That care in the nursing home is suboptimal largely because neither health profession educators, nor health care researchers, have really created an effective approach to developing or evaluating care of individuals residing in nursing homes.

We have argued about whether the medical or the social model of care fits the nursing home, when we should have recognized that neither model fits and nursing home. We have been smug and self-satisfied at times as we forced hospital models of medicine and nursing care and community social work models onto an environment which is clearly neither. The result is that we have a nonsystem of care and evaluation of care in our nursing homes.

The use of physical restraints is a direct result, I believe, of the use of a hospital-derived medical and nursing approach to nursing home care and the resultant over-reliance on technology applied to the individual rather than technology applied to the environment.

I think it is obvious to everyone engaged in providing health services to older persons that no single discipline is sufficient to provide comprehensive care to this group. The use of an interdisciplinary team has been widely seen as a solution in providing optimal care to older individuals residing in nursing homes. Indeed, Federal regulations require that the care of individuals in nursing homes be reviewed on admission and thereafter, usually on a quarterly basis, by certain groups of professionals.

Most often, what happens is that a group including nurses, social workers, and in many instances, physical and occupational therapists, dieticians, and occasionally a physician, are brought together to look at and develop a care plan. This very expensive and time-consuming activity often fails to arrive at suitable solutions because of the private foundations, to really develop this area in terms of both an education and a research approach. This provides a bridge to my other major point.

The other fundamental issue that I see in this area is the lack of funding to develop and then to evaluate the basis elements of treatment in nursing homes. That is the safety, efficacy, effectiveness, and appropriateness of the care of persons in nursing homes. Recent studies of patterns of medical care in the United States have produced strong arguments to support the position that there is substantial overuse of certain diagnostic and therapeutic procedures in medical care.

The use of restraints in nursing homes is an absolutely classic example of what happens when you do not demand that the safety and efficacy be proven prior to widespread use. The initial studies of safety and efficacy should be followed by studies that look at how a technology is being and whether those uses are appropriate.

From my own experience as well as from published, but largely anecdotal evidence, physical restraints and psychotropic drugs are often ordered by physicians following a conversation or phone call from a beleaguered nursing staff who appear to be trying to cope with a patient who is causing some kind of a disruption in the facility. What happens is that an unproven approach to what is often an acute and somewhat self-limited problem is then ordered and everyone thinks that they have solved the problem. There is seldom any data gathered after the restraints are ordered that examine whether their use was either effective or appropriate.

Several recent and more carefully designed research projects have documented significant emotional distress in physically restrained individuals and increasing incidence of falls with those given chemical restraints. Although the lack of appropriate controls limit the interpretation of this data in a definitive way as to whether restraints are, or are not safe or effective, there certainly have been questions raised about the safety of their use.

Even more disturbing to me is the lack of clear indications for the use of physical restraints and unequivocal evidence that restraints actually work when they are applied in a particular situation. I am unaware of any study that has clearly demonstrated safety and efficacy of restraints for any indication.

The Clinical Practice Committee of the American Geriatrics Society is attempting to develop guidelines for advising physicians on when or if physical or chemical restraints should be used in the nursing home setting. I think that this is a process that fits very nicely with what we heard that the Health Care Financing Administration is doing.

One of the things that I want to bring to your attention which I think is very important is the need for the documentation and the follow-up. What I am suggesting, with these draft guidelines, is that there must be consistent and clear documentation of the specific indication for the use of chemical or physical restraints. Then, if it is applied, there must be careful documentation that the chemical or physical restraint has substantially reduced the problem for which it was applied.

If it is said to reduce falls, one has to document how many falls have occurred, prior to the applying of the device, and then see if falls actually decrease after using restraints. This is just a first step in terms of looking at the overall problem with the use of restraints.

The other items relate to assuring that there is not an alternative that can be applied in that particular setting, but I think just as important is to ask the question: is this the most appropriate setting for this individual who has this problem?

In summary, while in one sense a ban on the use of physical or even chemical restraints in the nursing home might yield a net benefit at this point—I don't think there is any way that anyone can stand here and say exactly what the outcome would be—it will not solve what I believe is a more fundamental, more important problem, which is really to come up with a paradigm of providing safe and effective care to those older persons in nursing homes who have both cognitive and physical impairment.

The fundamental problem, I believe, is that we have failed to devote sufficient resources, either within the educational community or in sources of the research funding, to both develop approaches and then to evaluate the safety, efficacy, and appropriateness of those approaches which are developed. If we fail to change the paradigm, we will be back here in a year with another issue, and instead of moving ahead, we will simply have moved in circles.

Thank you very much.

Dr. Williams. Thank you very much, Greg.

It seems to me that a point that is included in Dr. Pawlson's comments as well as in comments made earlier relates to the issue of paying attention to the process by which we look at the question of what patients in nursing homes need. I think that if we would look at the process without having a prejudgment about the answer, as you are suggesting, then we may get to better answers.

Out next person on this panel is Dr. Dermot Frengley, who is Associate Professor of Medicine at Case Western Reserve University, a geriatrician with long-standing interest in clinical care of older people and in geriatrics education and research. He was one of the first to conduct studies on restraint use in older, hospitalized patients.

STATEMENT OF DR. DERMOT FRENGLEY

Dr. Frengley. Thank you very much, Frank. I am going to continue to address this issue of the hospitalized older patient. The reason for this is that acute care hospitals carry very powerful therapeutic images; consequently what is done in hospitals carries over and is seen as being an appropriate practice in a nursing home.

Most of the education of physicians and nurses takes place initially in acute care hospitals, so the practices that are engendered in that environment are often thought of as being correct, proper, good, in that hospitals are good places and, therefore, those things that are done in hospitals ought to be done in nursing homes.

We heard Dr. Pawlson say just now that this seems to be a rather unsatisfactory paradigm and it seems to me to be highly questionable at best. So the purpose of my talk is to look and see what we know about the practice of using restraints in hospitals. We will address four studies that have some very peculiar features to them.

If we can be plunged into lesser great light, I personally would be grateful and we will be able to see the slides.

These four studies have been published, three of them in the Journal of the American Geriatrics Society in 1986, 1987, and 1989 and the VA Minneapolis study from Dr. Lofgren and his colleagues is published in the American Journal of Public Health in 1989.

They are very curious. They all took place roughly at the same time and none of the investigators had the faintest idea that the others were conducting similar studies.

Some sort of curious groundswell was developing among some of the geriatricians around the country that what was going on in hospitals was not necessarily a very good idea and that the restraints, as we have heard today, are probably a red flag toward an unsatisfactory attitude or approach to the practice of care for elderly people.

Curiously, too, all of them took place in public institutions: The two Cleveland studies were from my own group in the large county hospital in Cleveland, and the other two from the Denver VA and the Minneapolis VA systems; Dr. Robbins and colleagues in Denver and Dr. Loxgren and colleagues in Minneapolis.

Here you see roughly what happened. In our first study we looked at all admissions on the acute medical wards and compared what happened to the restrained patients and the unrestrained patients. Likewise with Dr. Robbins' group at the Denver VA; they looked at all admissions over the age of 70 in both acute medical and surgical wards and then sampled in younger age groups.

The group at the VA Hospital in Minneapolis looked at the patients who were restrained to see what happened to them. Finally, in our repeat study, a couple of years later, we looked at both our acute medical floors and acute rehabilitation floors. In this second study from our group I will talk about just the data from the acute medical floor.

You see on the screen the numbers of patients who were included in the studies and a broad descriptive nature of the studies themselves. What was found was an incidence of 7.4 percent on our acute medical wards in our first study.

In Denver, at roughly the same time, it was 17 percent on the medical and surgical floors. In Minneapolis at around the same time, they had 6 percent incidence, and when we repeated our study, we had 13 percent on the acute medical floor that we were studying.

The age ranges in our first study were from 19, so young people are also restrained in acute care hospitals, up to 101. In the second study, 19 to 97. In the VA hospitals, with older populations in general, 54 to 95 in Denver and 50 to 98 in Minneapolis.

The lengths of stay were 16.2 days, 20 days, 13.4, and 14.2. Importantly in here is that in those three studies that included for comparison the unrestrained patients, the restrained people stayed in the hospital for slightly more than twice as long as the unrestrained patients. Clearly, there was something a bit odd going on.

The mortality rates were likewise very disturbing: 12 percent of our restrained patients died. There were, in fact, 24 people who died during that first study period, and 11 of them were restrained. I was very disturbed at the whole idea that people who were dying or were going to die were being restrained.

In Denver, 24 percent of the restrained patients died, and 21 in Minneapolis. In our repeat study, 13 percent died.

When we look at this and compare it with the unrestrained patients, some very startling information emerges. We find that few of the unrestrained patients died during these study periods, and these are the percentages shown here. The percentages of the unrestrained patients dying during these study periods were really very low. The solid bars are the percentages of restrained patients who died and the slashed bars are the unrestrained patients.

On this slide we have a look at physical impairments. These were measured in various ways so they are not exactly comparable studies, but nonetheless, they tell the same sort of story. Those patients who were restrained tended to be much more frequently physically impaired than the unrestrained patients. The solid bars are the restrained and the slashed bars are the unrestrained patients.

The next slide looks at cognitive impairments. Here, too, we find that many, many more of the restrained patients were cognitively impaired than the unrestrained patients where there were comparable groups.

Finally, what happened to these patients in terms of discharge? The unrestrained patients were more likely to be discharged to home and the restrained patients were far less likely to be discharged to home.

In summary, what this tells us comes as no great surprise; indeed findings that one would in fact anticipate; that it is the physically impaired and the mentally impaired frail sick patient who is likely to be restrained in a hospital. If the hospital practice does that, then is it not appropriate, as I have suggested, to do the same within a nursing home?

How, over the years in Cleveland, there has been a lot of discussion about the use of restraints. In this last summer, for a different purpose, I looked again to see what was happening within the hospital environment in Cleveland. Within our own hospital, in the acute medical floors, the use of restraints, using a point estimate, had dropped to 4.5 percent.

I also had the good fortune to explore other hospitals within Cleveland in much the same manner and I went to two large major teaching hospitals, both nonprofit private institutions, and there, the restraint use was about 6 percent on the acute medical wards. In two smaller community hospitals, it was around 7 percent.

It seems to me that this is, in fact, a reduction, because in walking around with colleagues in those hospitals, they were expecting to find more restraints in use than was actually happening. There is no question that in Cleveland at any rate, the use of restraints is being increasingly questioned for a variety of reasons. The schools of nursing now know that this is perhaps a wrong practice or one that is best avoided if possible.

Similarly, physicians are questioning the use of restraints, so I think there is a slow groundswell within the hospital community that there are real alternatives that can be considered. I know that my colleagues in geriatric medicine nationally are also starting to question the use of restraints. Dr. Lindsay is here from the University of Virginia, and he tells me that he likes to include on rounds the question, "Why is this patient restrained?"

It is clear that it is going to require an interdisciplinary approach to address this question. Physicians alone can not do it. We know that the use of restraints in hospitals is largely nurse-instigated or instituted and the physician tags along.

Our first study was of interest in this regard in that it was done to include the end of June and beginning of July when the change of interns and residents takes place. The nursing staff was constant throughout the study, but there was a total change of house staff, and we found that there was no change in the rate at which the restraints were applied. So it seems that it had nothing to do with our house staff and a great deal to do with the nurses. Nonetheless, the physicians must support nurses and nurses must support physicians and we must all be supported by our colleagues in the rehabilitation therapies in addressing this issue.

Thank you very much.

Dr. **Williams**. It's the nurses' problem, is that right, Lois? [Laughter.]

The last member of this panel is Dr. Lois Evans, Director of the Gero-Psychiatric Section at the School of Nursing of the University of Pennsylvania. As many of you know, she has conducted several studies regarding the use of restraints with older people and has served on two projects of the Hasting Center regarding ethics in health care.

Lois?

STATEMENT OF DR. LOIS EVANS

Dr. **Evans**. Thank you, Frank.

As with many of the problems that affect cognitively impaired, frail older people, the problem of physical restraint has really received very little attention until recently. Thus far, however, it has generated more emotional response than scientific, factual data through systematic research. The first slide will demonstrate where we are with our research based knowledge about restraint use.

Since 1973, we have only had 18 studies published which relate directly to the use of physical restraints. As you can see, the bulk of these have been in the past 5 years, with seven since January of this year. So the move is on to do more restraint-related studies.

The topic of physical restraint use has suddenly become a hot topic which can be demonstrated, I think, by the standing room only response we had at the Gerontologic Society of America meetings in the symposium on restraint use. Of the 18 reported studies, 9 of these studies, or half of them, have been conducted in hospital settings. Only six have been conducted in the long-term care setting and three of them have been conducted in mixed settings, either long-term care and hospital, or hospital and rehab facilities.

None of the studies were based in the community, although there is increasing anecdotal evidence that the elderly are not immune from being restrained in their homes as well. The research has been primarily patient-focused, with only one study that has examined staff decisionmaking behavior, and one that focused on facility practices.

All study designs have been descriptive, as shown in the next slide. Of these, seven of the studies were small exploratory studies, six were prospective in design, with five of those based in hospitals and one in a nursing home. Two of the studies were surveys; three were pre/post one-group evaluations of a change in practice. Only four of the studies report and compare findings from multiple sites, and one of these was a survey.

None of the studies were replications and none are experimental. Nevertheless, from this small beginning, we have learned some important things about the prevalence of the practice in acute and long-term care; the natural history of restraint use in nursing homes; the characteristics of the restrained; risk factors for restraint; physical, psychologic, behavioral, or mortality effects for patients; decisionmaking, rationale for restraint, beliefs and knowledge of alternatives of staff; and the context of restraint use in long-term care. We have also learned that restraints are ineffective in preventing falls.

As a summary critique, the few studies which exist suffer from their descriptive and retrospective nature, the limitations in sample size and selection, the use of single institutions usually the acute care hospital. Only a few support the iatrogenic, physiologic, or psychologic effects of restraint in a frail elderly population or their effects on staff.

None have compared the effectiveness of physical restraint versus alternative interventions in relation to outcome measures. None have compared designs of the various restraint products in terms of safety, comfort, or efficacy. There have been no prospective, controlled, multisite studies demonstrating the efficacy of a planned intervention in reducing restraint use in nursing homes. Thus, significant gaps exist.

Some have questioned: why do we need research on this problem? We already know that physical restraint has negative effects on frail older people. Yet many unanswered questions do remain, including whether restraints are bad for all older people in every circumstance.

Further, knowing alone seldom leads to doing, as has certainly been made clear in recent public health warnings to us regarding our smoking, diet, and exercise patterns. Thus, a complex phenomenon like the physical restraint of older people in nursing homes or hospitals will not change on the basis of knowledge alone. Other motivators must be identified to facilitate change in individual and institutional behavior.

Research can help us identify these factors. The multifaceted nature of the phenomenon should attract researchers from many fields, including ethics, the social and psychological sciences, the clinical sciences, the humanities, political science and law. In fact, although restraint use is frequently laid at nursing's doorstep, the problem requires an interdisciplinary approach for its full understanding and resolution.

Further, there are a plethora of theories from other fields which may have utility in framing studies for elder restraint. For example, from sociology, theories of systems, social roles, or imprisonment; psychological theories of victimization, learned helplessness, perception, burnout, sadism, or learning; or from the biological fields, theories of stress, circadian rhythms, or immobilization.

Take for example, the socio-cultural perspective. We know very little about the context in which restraints are used. What stimulates, motivates, and supports the staff to prescribe and apply the devices? What effect do the devices have on others' perceptions of the resident, and how do these perceptions contribute to the further deterioration of the individual's function? What part do the physical environment, the institutional philosophy, or the facility's prior experiences with legal liability or regulatory sanctions play in their use?

Are there differences in use depending on ethnicity, religious affiliation, payment status, or other sociocultural variables in particular facilities? What are the subjective experiences of patients, nurses, and families regarding the use of physical restraint, and what will be the effect on these same parties when restraints are less often used in a facility? Will all of the outcomes necessarily be viewed positively?

If a culture which supports safety at all costs, including widespread use of physical restraints, exists in some institutions, how might we initiate change toward a cultural value for individualized care? What would be effective incentives?

A sociologist interested in social movements will find this current reform movement reminiscent of others in our not too distant past. Documenting the effects of events such as today's symposium, the restraint research initiatives of prominent foundations and institutes, the passage and implementation of the nursing home reform legislation, and the work of radical flank abolitionists and outcomes of research will be very interesting to trace over time.

In addition, we perhaps have much to learn from a careful study of the history of the last restraint reform movement. Such data could be brought to bear on today's work in order to avoid the failures of that less than successful effort in American psychiatry.

From the sociopolitical perspective, the question must be asked: Why does the United States stand alone among developed contries in the widespread use of restraint with older people. From this perspective, also, studies of the effects of varying reimbursement systems on restraint use are of interest.

From an ethical perspective, the questions are many. Is beneficent restraint ever permissible and, if so, when? If persons with problematic behaviors are not restrained, what is the risk of violating other's rights in communal living situations? What are the relevant quality of life issues? Whose choice is the risk-taking anyway? How should informed consent for implementation or removal of restraint best be approached will frail elders?

Today, from a legal perspective, as we have heard, there is very little systematic investigation concerning legal constraints on restraints-free care. This information is urgently needed and the development of a revised and more appropriate standard of care based on research is also essential.

Studies in the biological sciences may also shed light on the issue of restraint. For example, a recently published study on circadian rhythms indicated that, in hamsters, physical restraint during the normal active period of the day can, by itself, induce changes in the circadian clock. How might this finding eventually help us explain some of the behavorial effects of prolonged daytime restraint in older adults? For example, nursing home residents who are restrained during the day have been shown to be three times more likely than the nonrestrained to exhibit sundown syndrome or evening confusion.

From the psychological perspective, preliminary investigation indicates that even a short restraint experience may have lasting effects on self-esteem and self-image in older adults. Additionally, recent studies indicate that nursing home residents exhibit more agitated behaviors and engage in less social behavior when retrained. More systematic data is needed on short- and long-term sequelae of restraint in terms of psychological, cognitive, behavioral, and emotional morbidity.

Finally, from a practice perspective, several questions come to mind. How do nurses and physicians decide to use or discontinue restraints? Are there patients for whom physical restraints may be beneficial and, if so, can a profile be developed? How can the design of restraint products be improved to produce safer, more comfortable, and less dehumanizing types of devices for those few situations deemed appropriate for such intervention? How could physical environments, equipment, and furnishings be redesigned to facilitate comfort, function, and quality of life?

Is there any real distinction between restraint and protective device, when the same garment serves both purposes, in terms of perceptions, effects, or ethical principles? Since the three major reasons for which restraints are prescribed are the risk of falling, interference with medical treatment, and control of disruptive behavior, support of current and ongoing research on these areas of problematic behavior is crucial. These include the NIH-sponsored initiative on falls and frailty and several studies supported by the Alzheimer's Disease Association, NIMH, and others on various types of problematic behaviors. Such studies increase our understanding of these problems and suggest alternatives for prevention and management which do not include physical restraints. We also need to know: how efficacious are the various alternatives to restrains for behavioral management in terms of such outcomes as cost, health state, functional status, and staff morale and turnover?

Studies of change in practice behaviors suggest that restraint use depends less on the number of staff than on their type and mix, level of training, and knowledge, skill, and sensitivity in interacting with older adults. Studies evaluating there variables would be of great interest.

Finally, models for individualized care must be developed and tested. The rising prevalence of physical restraint use with institutionalized, frail elderly, unprecedented in the previous century, is one visible symbol of the failure to deliver quality-care. Growing public awareness of this failure, in part, drives the current interest in research in the area.

The movement toward reduced restraint use with older people must be a thoughtful one, informed and guided by research-based evidence of ineffectiveness and harm of restraints and the utility of alternatives. Thus, much remains to be done.

Thank you.

Dr. **Williams**. Thank you very much, Dr. Evans.

Do we have a little bit of time for questions?

Mr. **Lewis**. Yes.

Dr. **Williams**. I just wanted to make a couple of comments. I was told that I could mention that the Commonwealth Fund Board, about a week ago, approved a plan where the Commonwealth Fund will be supporting some studies on the issue of the restraints and restraint-free care. I think that is a very pleasing step.

I also want to add that I just received a letter from Dr. Terri Brower, Professor in the School of Nursing at Auburn University. This was a follow-up to discussions at the workshop on restraints at the Gerontological Society that Dr. Evans referred to in which Dr. Brower points out that there is an epidemiologic study being begun on the deaths caused by restraints undertaken by a medical student and a medical examiner in cooperation. I think that the results of this rather intensive baseline review of deaths secondary to the use of restraints will be most interesting when it is available.

Mr. **Lewis**. Thank you all very much. Those were very interesting presentations.

I would like to invite those who presented earlier this afternoon to join us up here and we will then open the floor to questions concerning, not just the most recent presentations, but all of those. We have about 15 minutes for questions before we move into the final remarks for the symposium.

STATEMENT OF MARY LUCERO

Ms. **Lucero**. My name is Mary Lucero and I am a nursing home administrator in the State of Florida. Sometimes we are terrified of that when Connie Cheren is around. I also am a gerontologist and am now the President of Geratric Resources, which is a company that designs products to provide resources to nursing homes so that they do not have to use restraints for residents.

We are very proud to announce that we are the first awardees of a National Institute on Aging grant to design products for self-stimulatory wanderers who are Alzheimer's-type dementia patients. I am really excited to share with you that NIA has not waited until today to start looking at research. Self-stimulatory dementia patients are the highest at-risk-to-be-restrained group, primarily because they are in the middle and late stages of dementia.

One of the things that I wanted to address to the panel and ask—when you were talking, Dr. Pawlson and Dr. Frengley——

Mr. **Lewis**. Your microphone went dead.

Ms. **Lucero**. It's because I was going to talk to doctors about nurses and they don't want to hear it. [Laughter.]

One of the things that is happening in Florida, as Connie has shared, is that Florida is very excited about what we can do so that we can untie our elderly, but directors of nurses are also very concerned about whether or not they have the resources and the knowledge to do that. Connie is conducting some seminars in January and I am coming behind here and also conducting some to help them understand how they can deal with behaviors of dementia patients.

One of the things that is not happening—and I heard physicians say that nursing is the one that is asking them to restrain people because they call the physician and ask, "Can I tie them up?" Physicians are saying that nursing is asking, so we are saying yes.

I think that we need to recognize that one of the things that is happening in long-term care is that there is a gap that exists between the technical information that is coming out, especially pertaining to dementias, the pathophysiology, and the relationship to the behaviors that we are seeing accompanying that relationship.

Physicians are in a position where they are expected to keep more current with what is coming out new than, in my perception as a hands-on caregiver, nursing feels. I can't be giving care as well as being current on what is coming out on a daily basis.

You are prescribing restraints instead of prescribing alternatives, and you are not sharing a knowledge base that you have so that nursing understands the relationship between a brain-damaging illness and the resultant behavior. There is plenty of literature that lets us know that we can predict and expect some behaviors to be associated with certain types of brain damage.

Why is that not happening? That is my question.

Dr. PAWLSON. Let me reply.

I always like to reassure whenever this happens by saying that you are talking to the wrong doctor. I think that one of the clear things is that when you work in a long-term care setting, you realize that these sorts of problems, as Dr. Evans also noted, are multifactorial in the way these things happen.

I certainly did not mean in any way to say that the use of restraints is the fault of nurses. I don't think I said that in my remarks.

The misuse of restraints is everybody's responsibility, and it raises a couple of questions. Number one: how did this misuse get started anyway? Why didn't we evaluate restraint use when we first started using them? How can you have a device that is applied to millions of people across the country that has never been tested in terms of safety and efficacy? I think it is a fundamental problem in our whole health care system.

Number two is neither doctors nor nurses are well informed about the well-used restraints.

I think that nurses should be in leadership roles in long-term care facilities. It really has to be a collaboration between the physician and the nurse in order to find alternatives to restraints. It is really the responsibility of both.

When the nurse calls me up at 3 a.m. and says that Mr. Jones is screaming at the top of his voice and is pounding on the doors of all the other residents, it really is up to the two of us to figure out a solution to that problem, which does not mean that Mr. Jones should be tied down for the next 6 years. That is really what I was trying to say.

I don't think that either of those two professions has all the answers: Perhaps we have a lot to learn from our colleagues in rehabilitation, although, having participated in a number of rehab conferences, I am not sure that they have adopted all of their approaches to the nursing home either. I do think we have a lot to learn from them. I also believe that both medicine and nursing have a long way to go. One of things that I would propose—I certainly think that the AGS would support this, and I would love to have a nursing organization work with us, is to support a major national campaign to decrease the use of restraints and to promulgate the use of alternatives.

We are in the hot water together, and I don't think the nurses are any more culpable than physicians.

Mr. LEWIS. Dr. Frengley.

Dr. FRENGLEY. I commented on the idea that the images devised from hospitals have moved out into nursing homes. Dr. Joanne Lynn said to me earlier today that she thought that in the next 10 to 15 years, that will reverse; that the behaviors and compassionate kindly care that are increasingly being established in nursing homes will, in turn, creep back into hospitals. I think we are going to see that when there is more education of physicians and nurses in nursing homes.

I would like to pick up on what I thought was a rather marvelous comment from my colleagues on either side here, that we need to focus on the environment. Technology applied to the environment seems to me, obviously the right way to go.

Recently, we have been tackling the very difficult situation of an elderly woman who is confused and who likes to get up at night, so we have an electronic sensor on the bed. When she gets up, it goes off by sounding an alarm, and somebody goes to see that she is all right. We heard of a similar device for wheelchairs earlier today.

I think these are the approaches that we might be able to use to comfort care-given with the idea that there is at least an alternative that is mechanical. Somehow or another, a mechanical alternative seems to be much more acceptable than a people alternative. It seems to be cheaper, and more reliable as long as it doesn't break down, and so on.

I think that these mechanical alternatives that do not restrict or restrain exist and are going to be increasingly used in nursing homes, and then subsequently, applied in hospitals.

Dr. TORELL. It should be pointed out that solutions will not come just from nursing and medicine, but also from the other disciplines; physical therapy, occupational therapy, social work, activities, recreation, and probably mostly, from the nursing assistants themselves.

Ms. MITCHELL-PEDERSEN. I think that laying the blame doesn't necessarily help, but I think that nurses have a long a noble history of manipulating doctors, and they have a lot of power in this regard. If they can get on top of some other kinds of solutions—they have a lot of power in the system.

I think that what has happened for us since our change away from the use of restraints is that we have had to focus very differently on looking at behaviors labeled difficult, for whatever reason, among our patient population. We have had to develop very different ways of regarding "problem behavior," in looking at behavior in the context in which it occurs. This would be true whether it is occurring in nursing homes or in hospitals.

Behavior has many, many contributing factors: historical, cultural, emotional, psychological, physiological, and so on, which demands that almost every discipline participate. Partly, rather than focusing on the behavior, we need to look at behavior in context.

Mr. LEWIS. Any other comments or questions?

STATEMENT OF KATHLEEN CANTABEN

Ms. CANTABEN. My name is Kathleen Cantaben from New York State Health Department. I have two issues.

One is paper compliance, which we are always accused of—my colleagues can agree. We seem to throw paper at problems. I am much encouraged by the resident assessment instrument that is coming out because I think we need a basis of knowledge to do that.

I would like to ask Carter if, when she was in Scandinavia—what she came up with was continuity of relationship and attention to detail. A good assessment on the front end is one thing; implementing it is another.

What is it that is happening in Scandinavia that is not happening here?

Ms. WILLIAMS. I don't have enough information to answer that in the depth that I would like, but when you consciously put emphasis on maintaining relationship, you have a constant source of information and knowledge about this person.

In this country, often when I have raised that point, I have been told that it is dangerous to keep nursing assistants assigned to the same people. They must not get too dependent on each other. They are rotated every week or every month. Part of it is simply designing your system to achieve something different.

Ms. CANTABEN. One of the other things that we see, at least in Upstate New York, is a tremendous turnover in staff. There is a 60 to 100 percent turnover in staff per year on not only the nurses' aide, but also on the nurses' level. One of the things that I have not heard mentioned is looking at the labor force and how to attract people to this arena and to keep them there.

Ms. WILLIAMS. That is a problem throughout the country, and I don't know of any research on it, but I do know, anecdotally, of two units that developed care such as we have been talking about, individualized care, who met with the staff regularly and supported them and taught and they learned from each other. In both of these units, there was no turnover after a year. You can't guarantee that, but it is a much more interesting way to work and a much more meaningful way.

Ms. CHEREN. I would like to respond to that issue.

We find the same thing; that good facilities tend to maintain staff and people do not want to work in facilities that are providing primarily what we call body work, where their job is to bathe, dress, feed, and move people about the facility two or three times a day.

People want to work where they have an opportunity to become involved in the system of caring that allows people to get better, to focus on the highest functioning possible. I found that when I was working as a nurse, once we changed to permanent team assignments and once we refocused what the job was and redefined it.

I always challenge nursing home providers to go back and ask the nurses' aides, "What is your job?" If they tell you, "My job is to bathe seven residents today; to feed five residents; to dress 12 residents," then they are not focusing on restorative care.

Mr. **Lewis**. Any other comments?

Neville.

Ms. **Strumpf**. I am Neville Strumpf, University of Pennsylvania.

Dr. Pawlson made the excellent comment that failure to change the paradigm will bring us back again in a few years. At the risk of belaboring the point that history repeats itself, I do want to share one anecdote that relates beautifully to what Ms. Morris said earlier.

In 1813, when Samuel Tooke eliminated restraints at The Retreat in York, England, he devised something that he called moral treatment. The fundamental basis of moral treatment was to engage the residents in forms of occupation which would bring them into harmony with their environment.

As we think about the research that needs to be done and why we are here today, I think we also have to ask ourselves: what is it within us, that with all of the history and knowledge that we have, still leads us to persist in practices that are less than therapeutic for residents?

Mr. **Lewis**. Anyone like to comment further?

I think we have time for perhaps one more question.

STATEMENT OF MARION LEEMAN

Ms. **Leeman**. My name is Marion Leeman and I am from Manor HealthCare.

I am happy to say that I am celebrating my 30th year in taking care of the elderly. Those have been very happy years, but one of the sad things that I have seen over the past 30 years is that, when I first started working in taking care of the elderly, the nursing home that I worked at set the standards. They were saying, "This is the care that we should be giving. This is what we should be doing."

I have seen over the years—it's been a really sad experience for me—that we have become like sheep being led to the slaughter. We wait for the State to come in. Not everybody does this—I am speaking from my own experience. I keep saying that the States are regulating us to death.

A couple of years ago, I looked at that and I found out that maybe they were doing that because we were not doing our job. I have been here for 30 years, and 30 years ago, my first experience with an elderly person was a person who was in a restraint.

Thirty years later, we are still talking about it. Are we just talking about it? My point is that I want to thank the Kendal Corporation for putting this on. I think that it took a lot of courage even to do the restraint-free nursing homes. I want to thank them.

A bigger picture here is that, finally, a nursing home corporation has had the guts to get out there, do the survey, try it out, but not—if you will excuse the expression of a nurse—but not become constipated with the information. They have given it out to the rest of us. I want to thank them. [Laughter.]

Mr. LEWIS. Thank you for those remarks. [Laughter.]

I think we have come to the end of the regular presentations and the time for questions, so I would like to move to the final session, which is, "Where Do We Go From Here? A Call To Action."

Nancy Dubler, Director of the Division of Law & Ethics, in the Department of Social Medicine, Montefiore Medical Center and Associate Professor at Albert Einstein College of Medicine in New York, is highly regarded for her work on ethical decisionmaking in health care of the aging. She has directed numerous projects on decisionmaking and the elderly and serves on the Hastings Center Nursing Home Project on Ethical Care of Nursing Home Residents.

I give you Nancy Dubler.

STATEMENT OF NANCY DUBLER

Ms. DUBLER. Thank you. What a wonderful day it has been. Not only have the speeches and the presentations been eloquent and compelling, but they provide evidence to support the feeling of critical mass of professionals in support of change. We have heard from various professionals, who have recognized a problem and are determined to do something about it.

I can recall only one comparable perception in my professional life. That was in 1975 when I was working, as I still am, on issues involving prison health care. By that time there were a series of Federal court decisions holding that there was some concept of a Constitutional obligation to inmates, to provide health care. Indeed, in 1976, the Supreme Court stated that the Eighth Amendment protected an inmate's right to medical care while incarcerated. In 1975, however, there was this tremendous excitement among those of us involved in litigation and analyses, which seems comparable to what I have seen today. This discussion is part of the momentum toward change. The questions are: How much change; on what timetable; and who will spearhead that change?

I often like to speak about my favorite nursing home in rural Maine, Sandy River Nursing Home, which is run by two terrific health care professionals, a nurse and an anthropologist who related a story to me a few years ago. The tale involved a family conference which had assembled in their office including two residents of the nursing home who wanted to marry and their children, who were adamantly opposed to the mere discussion of such a prospect. Why? For any possible number of reasons:

First, the children might have thought that it was unseemly—here are these people in their eighties or nineties—why do they want to be married? Could they possibly be interested in sex? Nobody talks about sex in the nursing home. Second, they might have been concerned about some monetary issues, such as who would inherit from whom if one of the parents died. For whatever reasons the children were terribly opposed.

In the middle of this family conference, the son looked up at his father and said, "Dad, what are you going to do some morning when you wake up and there is this strange lady in your bed?" The father replied, "I am going to go poke, poke, poke—pretty lady, who are you?" And she said, "And if I can remember, I'll tell you." [Laughter.]

We must be concerned for those who cannot remember. Those are the people for whom we must set standards, not those who can make the decision to marry, or who can say clearly, "I do not want these restraints," but people who cannot be so clearly their own advocates.

I would like to talk about a few things in closing today, and I will try to be quite brief. I will begin with a few introductory comments and suggestions about possible conflicts in values and perceptions. Who are the parties with an interest in a restraint policy? What is a valid or an unsound policy? I will suggest to you, that restraints are, morally, legally, medically, and politically unacceptable. And finally, I'll comment on where we are likely to go from here.

Muriel Spark, in Memento Mori, which I think is one of the best teaching texts for geriatrics that we have, speaks of the "lacerating familiarity" in the way patients in the charity ward in an English nursing home were treated. They were treated either as infants or as idiots. They were treated with brusque movements, with dismissive responses, and when too bothersome, with restraints.

Restraints have presented a dilemma until today, because they seemed to support at least some definitions of the good. The good could be defined as: (a) preventing harm, (b) providing for the convenience of the staff (which is more sympathetically stated as, supporting the efficient functioning of staff), (c) supporting the autonomy of the patient, or (d) responding to the concerns of the family for safety. All of these have been offered as the philosophical basis for restraints as all define a goal that is, in some measure, a positive one.

But, we must ask: in whose perception? As our prior speakers have detailed today, there are many individuals involved in the provision of care to long-term care residents who have an opinion on what is the good and who have a stake in seeing their definition of the good win out over others.

Who are they? The staff, and staff is not a unitary term; includes administrators and workers in long-term care, who may have different interests, as may nurses and physicians; resident; family; supervisory agencies; insurers; the court system; the public; and the press—those are a lot of players, all of whom have a stake in seeing that their own definition of the good achieve hegemony in the field of competing justifications.

Over all of this, of course, floats the specter of legal action and possible liability. I like to say when I lecture to medical students and housestaff, that "anyone can sue for anything at anytime, and lots of people do". That perception which reflects, in my judgment, some bizarre aspects of American society is not a good basis for designing public policy.

We know, in the acute care context, that the huge rash of malpractice suits has served largely to line the pockets of aggressive attorneys. It has done very little to funnel money to those who have been injured, and it has done almost nothing to affect the quality of care. Our malpractice system is a deep functional exercise in compensating injured patients.

Why do we as a society, permit it to operate? Many of the people who make public policy, to wit, legislators, are lawyers. Self-interest is not the only thing that motivates individuals, but it can't be dismissed.

There are however, also other issues. Access to the courts is a terribly important principle of American society, and one with which we tamper at our peril. Yet, reference to this aberration in society—this sickness of litigation—is no way to set policy.

I have a rather straight forward way of thinking about compensation: as long as we have a health care system that doesn't provide care for all people, and as long as there are the inevitable negative consequences of health care interventions which are not fairly and equitably compensated we will have malpractice litigation. It would be silly for anyone who has been harmed not to pursue that route.

Restraining nursing home patients, however, as a function of public policy, I will argue to you is unsound morally, legally, medically, and perhaps even politically. It is morally unsound because restraining residents is humiliating; it is infantilizing. It causes morbidity. It is terrible, as has been noted, for the staff/resident relationship. It destroys the respect which must be a precondition to any mutual exchange. It is wrong, in short, to treat people as if they are objects. Restraining some residents treats them as if they are less human than others.

I also suggest to you that it is legally unsound. The best statement of the legal principle of patient self-determination is found in a 1914 New York State case called *Schloendorf* v. *Society of New York Hospitals* (211 NY 125 [1914]).

In that case, Judge Cardozo said, "Every human being of adult years and sound mind shall have a right to determine what shall be done with his own body." I am surprised that you are not all up on your feet yelling, "But these people are not of sound mind." I don't know that. Actually I don't know precisely what it means to be legally of "sound mind." I don't know as a lawyer, because the law is hopelessly unhelpful on this issue.

What does it mean to be of sound mind? If a resident says, "I don't want this restraint," I would suggest to you that for the purpose of deciding about restraints—and I would argue to you that capacity to make decisions is decision-specific—for that decision, this resident has sufficient capacity to have his or her wishes noted and respected.

Could that person decide whether or not to have complex brain surgery that might, or might not, redress the effects of a tumor which might, or might not, be malignant? I don't know. But that resident knows that he or she does not want to be restrained. I would argue that restraining that resident is, therefore, an assault. It is a violation not only of that resident's moral agency, but also of that person's legal authority to make decisions.

The vast majority of persons in long-term care have not been declared "incompetent" by a court. That statement leads me to what is known on the floors of Montefiore as "Dubler's Tantrum No. 1." That is: "liaison psychiatrists are not empowered to declare a patient incompetent. Only a court of appropriate jurisdiction, after a full adversary argument, has that right." Therefore, absent that court decision, I presume, and act as if, the patient not only has the right but also has the ability to comment on personally appropriate care.

The law is concerned with rights, with self-determination, with liberty, and with privacy. (At least until now, it has been concerned with the right to privacy—I don't know if that concern is going to survive this year's Supreme Court term.)

Many of you may know that the *Cruzan* case (*Cruzan* v. *Harmon,* 760 SW. 2d 408, Missouri 1988, en banc; cert granted 109 S. Ct. 3240, 1989) is being argued this Wednesday. This case involves the tragic situation of a woman in Missouri in a permanent vegetative state, whose parents, her legal guardians, would like to end the artificial provision of nutrition and hydration which is maintaining organ function.

I like to be clear about my biases. My bias is that these parents should have the right to interpret their daughters preferences and act on them. It is, in fact, a very critical case to which I will return when I comment on the issue of political soundness or unsoundness of restraints.

I would suggest to you that no resident who expresses a disinclination to being restrained can or should be restrained without a court order. It is quite as simple as that. I would not argue that in acute care, you could do surgery on a patient who objected to that surgery without a court order, whether or not you contested the decisional capacity of that patient. I think the same standard of judgment applies in long-term care.

I do think, therefore, that residents have the right to make decisions unless they have been deprived of that right, by a court or are clearly beyond reason in a nonresponsive state. Residents have the right to express opinions which should be respected even if they are somewhat confused or of diminished or fluctuating capacity. This is especially so since capacity to make decisions is decision-specific.

Whether issues of medical intervention can be decided upon by a resident will depend upon the capcity of the resident and the complexity of the situation is. However, a resident who does not want to be restrained clearly has the capacity to react and to express a preference.

Not only is capacity decision-specific, but it can fluctuate. Even when fluctuating, it should be respected. Someone today mentioned a "window of lucidity." If someone is fairly much in contact at 10 o'clock in the morning and is quite confused at 6 o'clock in the evening, but is careful, clear, and consistent about not wanting to be restrained, we have the obligation to respect this autonomy.

Autonomy in the elderly is not a unitary matter. It is not always consistent over time and it often needs support. Autonomy of elderly people is supported autonomy as, I would argue to you, that it is with all of us.

We talk about the sole and singular right of a patient to make health care decisions. How horrible it is when a patient truly has to make decisions alone. Patients make decisions with family and staff. Autonomy is brittle and fragile when it is unsupported by others.

Restraints are medically unsound. I work with a wonderful geriatrician who some of you know, Dr. Robert Kennedy, who comes from Great Britain, where he has been trained in geriatrics. He was trained to lower the bed if a patient falls out of bed, not to put up the rail. And, if you can't lower the bed, you put the mattress on the floor. If you put up the rail and the patient hops over it, the chances exist of a greater injury. Restraints don't seem to make much medical sense.

We have not yet seen randomized clinical trails to measure the effectiveness of restraints. If the FDA regulated these devices, there would have been a randomized clinical trials. Should this be encouraged? Perhaps?

This might be an interesting idea except for the fact that the New York Times had an article just today on the overwhelmed FDA; if we gave them this responsibility, we might have to give them an increased budget. It is clear even without clinical trials that the *use* of restraints has far outstripped any evidence for their effectiveness.

Now I come to arguments about what is politically unsound; this is mere speculation on my part. I am an attorney and denical ethicist who works primarily with persons with AIDS, demented elderly, and prisoners, which leaves my husband forever wanting me to get fired so I could go and get a real job and be a real lawyer like my law school classmates. But in the world of clinical ethics in which I work, some very interesting political developments have provided me backdrop for many events over the last years.

One political issue has been the "Right to Life" movement, which all of us know gained its popularity and became part of common discourse around the right to abortion. However, over the last years, the focus of many in the movement has moved from abortion to terminal care and care of the elderly. There are political stakes in how the discussions about restraints. Are we going to mitten people so that they cannot pull out their N/G tubes? Because, if we don't mitten them, they will pull out their N/G tubes. Will we restrain to preserve existence at any cost?

Politics in medicine, with abortion as an example, is a very complex matter. In the last few months, there has been a most surprising turn of events. What an extraordinary year this has been. We went from the Webster case to effective political activism in favor of abortion. We went from The Iron Curtain to the end of Communist Eastern Europe. The year 1989 will go down in the history books as a rather extraordinary year.

We have not yet seen in the area of restraints, however, the political system reacting to developing constitutional law. There was a case in New York State some years ago called the Case of Baby Jane Doe which ultimately involved the issue of whether newborns must always be treated for any condition, and if not, what standards would govern care. The Cruzan case is going to involve the issue of whether the elderly must always be treated. In this discussion, the ethics, of care providers, physicians, nurses, and administrators, who argue that quality of life is more important that the mere maintenance of organ function, may become important. Are we willing to restrain vast numbers of patients who attempt to refuse artificial food and fluids? Will this be a legal or a political decision?

Where do we go from here? I had a bit of a list when I came this morning. I've tried to listen carefully. Nothing that I have said in this summary has added in any measurable way to the excellent and careful presentations that preceded me. Some of the suggestions for where do we go from here predated the presentations and some, quite obviously, have emerged from the very eloquent arguments that were presented.

What should be our agenda?

First, we need to understand what is out there, how restraints are used, by whom, under what circumstances, for which residents. Second, we need research, not only epidemiological research, but also intervention research. We need to know about the safety and efficacy. That is such a stunningly clear point.

We don't permit the wholesale use of medical interventions on otherwise unsuspecting patients or residents in any other area without some proof that the plan is a good one. In the use of restraints we have proceeded haphazardly. We need well-designated research by the academic community on these issues.

I am very encouraged that the Commonwealth Fund has decided to focus some of its attention, which I assume means some of its money, which I assume brings some academic focus, on these issues. I think that is important.

Third, as has already been suggested, we need the support of the National Institute of Aging. The Institute could be very important, not only in suggesting new areas for research, but also in thinking about the technical assistance and support which nursing homes will need to take this step.

Fourth, we need guidebooks. We need workbooks. We need handbooks. We need documents that say, "This is how you do it, step by step, and if it doesn't work through Path A, then your institution might need Path B."

I don't ever premise my analysis of public policy on the evil intention of caregivers. It doesn't turn out to the justified. People and especially care givers do not, by and large, have evil intentions. They are, generally, decent folk, overwhelmed by what they are doing with insufficient supports to think about alternative routes for care.

I did think for a while that I was going to suggest litigation, but that seemed to me so odd a thing for me to suggest. I was going to suggest that maybe advocate groups could sue the nursing homes for putting on the restraints, but in fact, I think that we can effect the use of restraints without involving the court system. It is not an awfully good idea to develop public policy through litigation. It supports the development of issues in a rather bizarre patterns.

Where do we go? Well, today has been a wonderful event. Not a start, because clearly, what we see from today, is an issue in development. We have all come in, in the middle; the beginning was the work of the people from Kendal. Academics have begun analyzing data. Government has evidenced through the new nursing home regulations in OBRA. This is not a movement—if we call it that—in its infancy. It is a movement on the edge of maturity.

I end with the following. Language is always such an interesting window on events. Twice today, I heard phrases that I found quite revealing.

Senator Heinz said this morning, "Preaching the gospel of restraint-free care," and Carter Williams said later in the day, "Once you have seen it, you have got to bear witness." I thought those were very interesting appeals on a level of discourse different from that of data and analysis. These phrases appeal to morality, and to a commitment to the humanity of residents.

I predict that we are going to see good emerge on these issues in the next few years. It has been a wonderful day in which to participate and a special opportunity to think about where we are going.

Thank you.

Mr. LEWIS. I know I speak for all when I say that we are very grateful for those challenging and inspiring remarks.

We would like to close today with Bill Benson of the Committee. Bill would like to say a few words to us as we bring our symposium to a close.

It has been a remarkable day for my organization and for my staff. I know that this is the culmination of a great deal of effort. We have been most grateful for the wholehearted cooperation of the Senate staff.

Bill, I turn the podium over to you with many, many thanks for this day.

STATEMENT OF WILLIAM BENSON

Mr. BENSON. Thank you, Lloyd.

If Nancy is not enough of a hard act to follow, then imagine following the entire lineup for the day. I am in the unenviable position of not only following the outstanding speakers before me, but also trying to accomplish something that is rarely ever accomplished on Capitol Hill. That is, having an event end on a timely basis. If I do my part, you will be out of here before 4:30, and I shall try to do that as best I can.

This is a very unusual event for serveral reasons. One is that it is an all-day event. You don't see that on Capitol Hill very often. In fact, when this event was planned, we on the staff fully expected that Congress would still be in session, expecting that it would go right up to Christmas Eve before letting us go on to other matters, such as this. Tying up an entire date was really a substantial commitment, but this subject merited it entirely.

It is also unusual because this is a symposium, not a hearing. While this is a fairly formal event, it certainly lacks the formality of a hearing. A hearing lacks the kind of exchange with the questions and answers and thoughtful comments from the audience that we saw here today. That was a very important contribution to today's event.

Finally, what made this most unusual for Capitol Hill is the fact that the planning was done by a planning committee made up of not only representatives from Kendal and from our staff, but also made up of a variety of other folks. There were probably 25 people on the core planning committee, plus many others who contributed throughout the process.

I forget exactly how many formal meetings took place, but a tremendous amount of planning went into this event, involving people from the provider community, the advocate community, the regulatory community, the academic community, and other places. This makes it a very unusual event, one that we feel has been exceedingly effective. You can be sure that Senator Pryor and Senator Heinz, and the Aging Committee in general, are going to want to replicate in tackling other issues that are ahead of us in the coming year and beyond.

I have a few comments before I give a few thanks and reiterate some of the thank yous from this morning. You know just how well-deserved those thanks really are.

When Kendal came to us this past spring and said, "We are on a mission. We have something we are deeply committed to and we think there is a role for the Senate Special Committee on Aging to play." We thought that it was an interesting notion, certainly something that sounds terribly important, but: is it the kind of thing that we should devote a symposium to, whether for 5 hours, 3 hours, or 8 hours? Is it the kind of thing that will merit the attention we would like it to see? Is the timing right for something like this?

In fact, as today has demonstrated and the events over the past 6 months have demonstrated, the timing was more than right. This is, as Nancy said, a subject that is not in its early stages. It is moving along rather nicely. In fact, I had thought of using the term critical mass in my comments as well because it seems like that is occurring.

Not only is it evidenced by the fact that we had some 400 people from all over the country register to participate in this event, but also, once we talked with Kendal initially and began planning for it, we became much more attuned to how people across the country were talking about this subject.

This past May, I attended a meeting in Chicago for ombudsman from around the country in the field of long-term care. While there, I heard Carter Williams espousing her views in a very compelling fashion about this particular issue. Carter Williams believes this is terribly important and Kendal does, and we began to hear it from people around the country.

Then as news began to unfold that we would do this event, it became clear that there are plenty of voices across this Nation that are interested, committed, and trying to do what they can to help this movement along. It is an issue that the time is definitely right for, and all of you are a great part of that.

It seems to be quite a coincidence that, in order to support the microphone, we needed some props, and it so happens that the book that was chosen, because of its thickness, is a hearing print from this committee entitled, "Nursing Home Care: The Unfinished Agenda." That was not deliberate. It is a very thick two-volume set that we still had some copies of in stock.

I point that out because it is very apropos to today's discussion. Several years ago, the Senate Aging Committee conducted a series of hearings on the issue of nursing home reform and quality of care; a controversial series of hearings. We believe that this played a major role in helping the Institute of Medicine's effort to create a major nursing home reform effort to become reality.

In fact, I think that all of you know that OBRA 1987 included substantial reforms dedicated to improving the quality of life for nursing home residents and, for the first time, directs the entire effort toward the individual autonomy of residents in long-term care facilities.

This report came out before OBRA 1987 became reality. This is still an unfinished agenda. There are many things that we are committed to doing in the area of nursing home reform that still need to be done. This is no small part of that today.

We just came off of a tough effort over the last 6 months, trying to make some technical and substantive changes and amendments to the OBRA 1987 nursing home requirements. We had some success, and with some of the issues we pursued, we were not successful.

Senator Pryor and Senator Heinz, both of whom, as has been pointed out before, have a long-standing commitment to improving the quality of life for nursing home residents, are going to continue with that unfinished agenda, including some corrections and some amendments to OBRA 1987.

Today's issue, as important as it is, is obviously subsumed within the broader issue of ensuring that individuals who reside in long-term care facilities have a good quality life and that their autonomy is treated with great respect and enhanced in whatever ways are possible. As I think was evidenced by many speakers today, that has many different dimensions. The task for us, the Aging Committee, as part of the legislative process here on Capitol Hill, is to find all the opportunities to promote that agenda of autonomy and independence for residents in long-term care facilities, and to find ways to look at the issue of reducing or eliminating the use of restraints.

For example, there was reference earlier today to the importance of recreational activities. We would add to that the importance of various kinds of social work services.

We were not successful this year in improving language with regard to the importance of activities, recreational programing, and social services in facilities. We certainly look to you to help us in that effort to make sure that this important element of providing long-term care gets the attention it really deserves. That is a mission that I know Senator Pryor will continue, and we will need your help in that regard.

Training is terribly important. We have just been through a lengthy process of trying to make some technical corrections to the nurses' aide training requirements from OBRA 1987. We are going to be at that process for a long time as that takes hold and we really see a commitment to adequate training everywhere in the country for nurses' aides. Clearly, as many speakers said today, we have to go well beyond that.

We have to improve all who provide services in the long-term care setting. That certainly includes physicians, nursing staff, and everybody else. In particular, the need to involve physicians in this whole issue of long-term care, much less the use of restraints, is something that is going to take a great deal of attention, and we must do that.

There are a number of issues in the long-term care area that do relate to the use of restraints that we can tackle. One that I would prefer to avoid discussing because I certainly don't have any answers to it, but which we can not overlook, is the issue of financing. It would be easy to stand up here and avoid that discussion, but we can not do that.

We know that financing of long-term care weighs heavily on providers' and everybody else's minds. How are we going to have the resources to provide the staffing to do the things that are necessary? That is a challenge that is a very difficult one, but certainly, it is one that we just have to embark upon together. We have a tough row to hoe ahead of us in the aftermath of Catastrophic Care, but whatever the financing, whether it is Medicare, Medicaid, private insurance, or some new comprehensive long-term care program, we have quite a bit of work to do. We are going to need your help in that effort, as well to ensure that we use what we have better and that, where it is inadequate, we do what we can to make sure that funding is adequate.

We need to tackle the technology side of things. We will to meet soon with the Office of Technology Assessment on some of their projects, to see to what extent they have grappled with the issue of appropriate technology in trying to minimize restraints or assess alternatives. We would like to know more about what they are doing and how we might encourage their efforts.

Looking down the road, I am not sure what I can tell you about the role of this committee in moving the restraint-free agenda. I certainly can not tell you that we have a piece of legislation ready to move because we don't. We would like to look at what further roles the Federal Government should play in this area. We would like to do that in the same way that the planning for this event has occurred; in a consensus fashion.

We need to tackle the technology side of things. We will meet everybody in the audience, to find a way that is appropriate and is the right way to make public policy in this area. I anticipate that we will call several working groups together over the next few months to talk about what might be done, not only legislatively, but also in other areas, too. We believe that we are going to have to continue oversight activities over the Health Care Financing Administration to ensure that all of the many different aspects of OBRA 1987 are followed—with the kind of commitment that all of you believe is necessary to make some of those improvements worthwhile.

We know that an educational role by this committee and by the Congress is necessary, not only through dissemination of the print that will come out of this hearing, which I am very excited about seeing, but more importantly, by finding other avenues to promote, to educate, and to move this agenda. One area that I am certain you will see some more interest in on our part is a more detailed look at the use of chemical restraints.

Those of you who may follow some of Senator Pryor's actions know that he has a major interest in a lot of different aspects of the use of drugs and medications in our society. Combined with his interest in long-term care, that is likely to be something that he is going to want to us to tackle in great detail, and we will do that.

Beyond that, let me say that we are open to looking at other ways to help push this agenda, if you will, or this commitment to reduce the use of restraints, and to perhaps someday eliminate their use. I think that that this committee stands ready to work with you in making that happen.

Let me now say some quick thank-yous. I have to reiterate that the Kendal Corporation and the staff under Lloyd Lewis' leadership have pioneered so much in the improvement of long-term care. Certainly, this area is no exception.

Beyond Lloyd, his staff, Jill, Beryl, Dawn Papougenis, Curt Torell, and Gary Winzelberg, made up an extraordinary team to make this happen. The planning committee in general deserves a lot of recognition, as do the various organizations that participated and offered their advice, guidance, and time in helping us do this.

Certainly, all of you who are attending today have come from long distances. I believe that all of the speakers paid their own way to be here. That is a measure of their commitment to this issue.

Finally, I would like to thank the staff of the Aging Committee, particularly those who work with me in the health and housing team, and especially Holly Bode, who worked very hard to make this happen. This was a major effort involving many parties.

On that note, let me say thank you to everyone for being here. You have helped to make us far more aware of the importance of this issue than we might have been before. We knew it was an important one, but we are staggered by the quality and the interest that has been demonstrated today.

Thank you all very much. We look forward to working with you on this in the future.

[Whereupon, at 4:28 p.m., the symposium was adjourned.]

APPENDIX 1

Resource Packet

"UNTIE THE ELDERLY"

Quality Care Without Restraints

A Symposium Co-Sponsored by the
U.S. Senate Special Committee on Aging
and
The Kendall Corporation

December 4, 1989

Prepared by	Printed by
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ADDRESSES & PHONE NUMBERS OF SYMPOSIUM PARTICIPANTS

Ms. Joanne Rader, R.N. M.N.
Director, Mental Health Department
Benedictine Nursing Center
540 South Main Street
Mount Angel, Oregon 97362
(503) 845-6841

Mr. Fred Watson
Executive Director
Christian City Convalescent Center
7300 Lester Road
Atlanta, Georgia 30349
(404) 964-3301

Mr. David Mettler
Director of Risk Management
Hillhaven Corporation
1148 Broadway Plaza
Tacoma, Washington 98401-2264
(206) 572-4901

Arnold Silverman, Ph.D.
President
Skil-Care Corporation
167 Saw Mill River Road
Yonkers, New York 10701
1-800-431-2972

Ms. Mildred Simmons
President Elect
National Association of Health Facilities
Licensure and Certification Directors
Department of Health Facilities
4210 East 11th Avenue -- Room 254
Denver, Colorado 80220
(303) 331-4990

Alan Reeve Hunt, Esq.
Montgomery, McCracken, Walker and Rhoads
Three Parkway - 20th Floor
Philadelphia, Pennsylvania 19102
(215) 5563-0650

Mr. Marshall B. Kapp, J.D., MPH
Professor
Department of Community Medicine
School of Medicine
Wright State University
Box 927
Dayton, Ohio 45401
(513) 873-3313

Ms. Lynne Mitchell Pederson, R.N.
Clinical Nurse Specialist
St. Boniface General Hospital
409 Tache Avenue
Winnipeg, Manitoba   CANADA R2H 2A6

Ms. Henrietta Roberts
Executive Director
Stapely in Germantown
6300 Green Street
Philadelphia, Pennsylvania 19144
(215) 844-0700

Mrs. Carter Catlett Williams
Social Work Consultant in Aging
5202 West Cedar Lane
Bethesda, Maryland 20814
(301) 986-0108

Ms. Connie Cheren, R.N.
Director
Office of Licensure and Certification
State of Florida
2727 Mahan Drive
Tallahassee, Florida 32308
(904) 487-2527

Mr. Alan Friedlob
Nursing Home Branch Chief
Health Care Financing Administration
6326 Security Boulevard
2DR Meadows East Building
Baltimore, Maryland 21207
(301) 966-6776

Ms. Sarah Burger
National Citizens Coalition for Nursing Home Reform
1424 16th Street N.W.
Suite L2
Washington, D.C.   20036
(202) 797-0657

Dermot Frengley, M.D.
Associate Professor
Division of Restorative and Geriatric Medicine
Case Western Reserve University
MetroHealth Medical Center
3395 Scranton Road
Cleveland, Ohio 44109
(216) 459-3952

Greg Pawlson, M.D., M.P.H.
Professor and Acting Chairman
Department of Health Care Sciences
George Washington University Medical Center
2150 Pennsylvania Avenue, N.W.
Suite 2B-418
Washington, D.C. 20037
(202) 994-4439

T. Franklin Williams, M.D.
Director
National Institute on Aging
Room 2C02, Building 31
9000 Rockville Pike
Bethesda, Maryland 20892
(301) 496-9265

Ms. Nancy Dubler, LL.B.
Associate Professor
Department of Social Medicine
Albert Einstein College of Medicine
Montefiore Hospital and Medical Center
111 East 210th Street
Bronx, New York 10467
(212) 920-6226

Ms. Lois Evans
University of Pennsylvania School of Nursing
Nursing Education Building
420 Guardian Drive
Philadelphia, PA 19104-6096
(215) 898-7137

Ms. Anne Morris
American Occupational Therapy Association
1383 Piccard Drive
P.O. Box 1725
Rockville, Maryland 20850-4375
(301) 948-9626

The Kendal Corporation
P.O. Box 100
Kennett Square, PA 19348
(215) 388-7001
Staff contacts: Jill Blakeslee, Beryl Goldman, Lloyd Lewis,
Dawn Papougenis, Curt Torell, Gary Winzelberg

U.S. Senate Special Committee on Aging
Dirksen G-31
Washington, D.C. 20510-6400
(202) 224-5364
Staff contacts: Holly Bode and Bill Benson

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1987 OMNIBUS BUDGET RECONCILIATION ACT

Subtitle C—Nursing Home Reform

(parts concerning use of restraints)

PART I—MEDICARE PROGRAM

SEC. 4201. REQUIREMENTS FOR SKILLED NURSING FACILITIES.

SEC. 1819. "(b) REQUIREMENTS RELATING TO PROVISION OF SERVICES.—

"(1) QUALITY OF LIFE.—

"(A) IN GENERAL.—A skilled nursing facility must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident.

"(2) SCOPE OF SERVICES AND ACTIVITIES UNDER PLAN OF CARE.—A skilled nursing facility must provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, in accordance with a written plan of care which—

"(A) describes the medical, nursing, and psychosocial needs of the resident and how such needs will be met;

"(B) is initially prepared, with the participation to the extent practicable of the resident or the resident's family or legal representative, by a team which includes the resident's attending physician and a registered professional nurse with responsibility for the resident; and

"(C) is periodically reviewed and revised by such team after each assessment under paragraph (3).

"(3) RESIDENTS' ASSESSMENT.—

"(A) REQUIREMENT.—A skilled nursing facility must conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity, which assessment—

"(i) describes the resident's capability to perform daily life functions and significant impairments in functional capacity;

"(ii) is based on a uniform minimum data set specified by the Secretary under subsection (f)(6)(A);

"(iii) in the case of a resident eligible for benefits under title XIX, uses an instrument which is specified by the State under subsection (e)(5); and

"(iv) in the case of a resident eligible for benefits under part A of this title, includes the identification of medical problems.

"(c) REQUIREMENTS RELATING TO RESIDENTS' RIGHTS.—

"(1) GENERAL RIGHTS.—

"(A) SPECIFIED RIGHTS.—A skilled nursing facility must protect and promote the rights of each resident, including each of the following rights:

"(ii) FREE FROM RESTRAINTS.—The right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. Restraints may only be imposed—

"(I) to ensure the physical safety of the resident or other residents, and

"(II) only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances specified by the Secretary) until such an order could reasonably be obtained.

PART 2—MEDICAID PROGRAM

SEC. 4211. REQUIREMENTS FOR NURSING FACILITIES.

Sec. 1919. "(b) Requirements Relating to Provision of Services.—

"(1) Quality of life.—

"(A) In general.—A nursing facility must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident.

"(2) Scope of services and activities under plan of care.—A nursing facility must provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care which—

"(A) describes the medical, nursing, and psychosocial needs of the resident and how such needs will be met;

"(B) is initially prepared, with the participation to the extent practicable of the resident or the resident's family or legal representative, by a team which includes the resident's attending physician and a registered professional nurse with responsibility for the resident; and

"(C) is periodically reviewed and revised by such team after each assessment under paragraph (3).

"(3) Residents' assessment.—

"(A) Requirement.—A nursing facility must conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity, which assessment—

"(i) describes the resident's capability to perform daily life functions and significant impairments in functional capacity;

"(ii) is based on a uniform minimum data set specified by the Secretary under subsection (f)(6)(A);

"(iii) in the case of a resident eligible for benefits under this title, uses an instrument which is specified by the State under subsection (e)(5); and

"(iv) in the case of a resident eligible for benefits under part A of title XVIII, includes the identification of medical problems.

"(c) Requirements Relating to Residents' Rights.—

"(1) General rights.—

"(A) Specified rights.—A nursing facility must protect and promote the rights of each resident, including each of the following rights:

"(ii) Free from restraints.—The right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. Restraints may only be imposed—

"(I) to ensure the physical safety of the resident or other residents, and

"(II) only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances specified by the Secretary) until such an order could reasonably be obtained.

"(D) Use of psychopharmacologic drugs.—Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan (included in the written plan of care described in paragraph (2)) designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually an independent, external consultant reviews the appropriateness of the drug plan of each resident receiving such drugs.

1987 OMNIBUS BUDGET RECONCILIATION ACT

Subtitle C—Nursing Home Reform

(parts concerning use of restraints)

PART I—MEDICARE PROGRAM

SEC. 4201. REQUIREMENTS FOR SKILLED NURSING FACILITIES.

Sec. 1819. *"(b) Requirements Relating to Provision of Services.—*

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"(A) In general.—A skilled nursing facility must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident.

"(2) Scope of services and activities under plan of care.—A skilled nursing facility must provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, in accordance with a written plan of care which—

"(A) describes the medical, nursing, and psychosocial needs of the resident and how such needs will be met;

"(B) is initially prepared, with the participation to the extent practicable of the resident or the resident's family or legal representative, by a team which includes the resident's attending physician and a registered professional nurse with responsibility for the resident; and

"(C) is periodically reviewed and revised by such team after each assessment under paragraph (3).

"(3) Residents' assessment.—

"(A) Requirement.—A skilled nursing facility must conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity, which assessment—

"(i) describes the resident's capability to perform daily life functions and significant impairments in functional capacity;

"(ii) is based on a uniform minimum data set specified by the Secretary under subsection (f)(6)(A);

"(iii) in the case of a resident eligible for benefits under title XIX, uses an instrument which is specified by the State under subsection (e)(5); and

"(iv) in the case of a resident eligible for benefits under part A of this title, includes the identification of medical problems.

"(c) Requirements Relating to Residents' Rights.—

"(1) General rights.—

"(A) Specified rights.—A skilled nursing facility must protect and promote the rights of each resident, including each of the following rights:

"(ii) Free from restraints.—The right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. Restraints may only be imposed—

"(I) to ensure the physical safety of the resident or other residents, and

"(II) only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances specified by the Secretary) until such an order could reasonably be obtained.

---

on the acute general medical ward but was not used on the rehabilitation wards since this index has not been developed or tested for this setting.[30] Seven distinct variables were rated independently in increasing levels of severity from 1 to 4 by two of the investigators (L. C. M., J. D. F.), who were trained in the use of the index and had achieved a follow-up inter-rater reliability of 0.88 and a weighted kappa of 0.91.

Verbal consent was obtained from the nursing staff and patients before any interview. The selection, consent, and data collection process met the approval of the hospital's institutional review board.

Statistical Analysis The statistical computer packages of SAS and BMDP were used for analyzing the data.[31,32] Dichotomous variables were assessed by the χ^2 test and Fisher's exact test. Rank data were assessed between groups by the Mann–Whitney U test. Continuous data were assessed by analysis of variance followed by pairwise *t*-tests with Bonferroni adjustment for multiple comparisons.

"Predictors" of the first use of a physical restraint were assessed by logistic regression for each setting. The logistic model was chosen for the multivariate analysis since the dependent variable, presence of physical restraint, was a dichotomous variable. Moreover, the logistic regression model allows for nominal independent variables. The relative risks of the independent variables depend upon the specific values of the other covariates. Therefore, we estimated the relative risk for each independent variable by assuming mean values for all the other variables as described by Cupples and colleagues.[33]

RESULTS

Acute General Medical Patients

All Patients Thirty-five (13%) of the 278 study patients admitted to the acute general medical ward were physically restrained at some time during their hospitalization. There were no statistical differences between the restrained and the unrestrained patients in terms of their gender or marital status. A significantly higher proportion of white patients were restrained as compared to nonwhites. Restrained patients tended to be older, admitted from nursing homes, and discharged to nursing homes (Table 1).

Sixty percent of those restrained had a psychiatric diagnosis, compared to 31% of those who were not restrained ($P = .001$, χ^2 test). Major tranquilizers were used more frequently in the physically restrained group (20% *vs* 4%, $P < .001$, χ^2 test), while the use of the hypnotics and sedatives were comparable between the two groups.

Physically restrained patients had more serious cognitive deficits than the unrestrained patients at admission ($P = .015$, Mann–Whitney test) and at discharge ($P = .018$, Mann–Whitney test). Indeed, only three (11%) of those restrained had no cognitive impairment noted at admission, as compared to 85% of those not restrained. The restrained patients had lower Barthel scores of physical function as compared to the unrestrained patients at both admission and discharge (Admission: $\bar{X}$ (± SD): 23.6 [± 30.1] *vs* 81.1 [± 25.7], $P < .001$/Discharge: 28.3 [± 33.3] *vs* 91.9 [± 20.8], $P < .001$, Mann–Whitney test).

Within the physically restrained group, the mortality rate was found to be significantly higher than in those patients not restrained (Table 1). Greater morbidity also existed in the restrained group. Sixteen (46%) of the physically restrained patients were in the two highest severity of illness ratings as compared to 15 (6%) of the unrestrained group. Furthermore, not one of the restrained patients had the lowest severity of illness rating ($P < .001$, Mann–Whitney test). The average hospital length of stay was almost twice as long as that of the unrestrained group (14.2 [± 11.7] *vs* 7.5 [± 8.9], $P = .01$, *t*-test). Twenty-eight percent of all the patients had at least one complication, most of which were minor. Hospital complications occurred significantly more often in those with physical restraints with the exception of procedure- and medication-related complications (Table 2).

Power analyses were calculated for all negative findings using an alpha = 0.05 and the actual data. The power values ranged from 0.63 (procedure complications) to 0.88 (gender) with all items above 0.80 except for procedure complications and medication complica-

TABLE 1. CHARACTERISTICS OF RESTRAINED AND UNRESTRAINED PATIENTS ON AN ACUTE GENERAL MEDICAL WARD ($n = 278$)

Variable	Restrained ($n = 35$)	Unrestrained ($n = 243$)
	n (%)	n (%)
Admission Source*		
Home	25 (71)	219 (90)
Boarding/Nursing Home	9 (26)	10 (4)
Other Hospital	1 (3)	14 (6)
Discharge Disposition†		
Home	11 (31)	212 (87)
Boarding/Nursing Home	14 (40)	11 (5)
Other Hospital	5 (14)	17 (7)
Died	5 (14)	3 (1)
Race‡		
White	28 (80)	153 (63)
Nonwhite	7 (20)	90 (37)
Age (years)§		
$\bar{X}$ (± SD)	64.6 (± 21.4)	54.8 (± 17.8)
Range	19–97	18–93

* $\chi^2 = 22.58$, $P < .001$.
† $\chi^2 = 69.62$, $P < .001$.
‡ $\chi^2 = 3.986$, $P = .046$.
§ $t = -2.60$, $P = .05$.

PART 2—MEDICAID PROGRAM

SEC. 4211. REQUIREMENTS FOR NURSING FACILITIES.

Sec. 1919. "(b) Requirements Relating to Provision of Services.—

"(1) Quality of life.—

"(A) In general.—A nursing facility must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident.

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"(A) describes the medical, nursing, and psychosocial needs of the resident and how such needs will be met;

"(B) is initially prepared, with the participation to the extent practicable of the resident or the resident's family or legal representative, by a team which includes the resident's attending physician and a registered professional nurse with responsibility for the resident; and

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"(A) Requirement.—A nursing facility must conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity, which assessment—

"(i) describes the resident's capability to perform daily life functions and significant impairments in functional capacity;

"(ii) is based on a uniform minimum data set specified by the Secretary under subsection (f)(6)(A);

"(iii) in the case of a resident eligible for benefits under this title, uses an instrument which is specified by the State under subsection (e)(5); and

"(iv) in the case of a resident eligible for benefits under part A of title XVIII, includes the identification of medical problems.

"(c) Requirements Relating to Residents' Rights.—

"(1) General rights.—

"(A) Specified rights.—A nursing facility must protect and promote the rights of each resident, including each of the following rights:

"(ii) Free from restraints.—The right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. Restraints may only be imposed—

"(I) to ensure the physical safety of the resident or other residents, and

"(II) only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances specified by the Secretary) until such an order could reasonably be obtained.

"(D) Use of psychopharmacologic drugs.—Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan (included in the written plan of care described in paragraph (2)) designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually an independent, external consultant reviews the appropriateness of the drug plan of each resident receiving such drugs.

5316 Federal Register / Vol. 54, No. 21 / Thursday, February 2, 1989 / Rules and Regulations

Regulations concerning use of restraints.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 405, 442, 447, 483, 488, 489, and 498

[BERC-396-FC]

Medicare and Medicaid; Requirements for Long Term Care Facilities

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Final rule with comment period.

§ 483.15 Level A requirement: Resident behavior and facility practices.

(a) *Level B requirement: Restraints.* The resident has the right to be free from any physical restraints imposed or psychoactive drug administered for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

(h) *Level B requirement: Accidents.* The facility must ensure that—

(1) The resident environment remains as free of accident hazards as is possible; and

(2) Each resident receives adequate supervision and assistive devices to prevent accidents.

(l) *Level B requirement: Drug Therapy.*—(1) *Unnecessary drugs.* Each resident's drug regimen must be free from unnecessary drugs.

(2) *Antipsychotic Drugs.* Based on a comprehensive assessment of a resident, the facility must ensure that—

(i) Residents who have not used antipsychotic drugs and are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition; and

(ii) Residents who use antipsychotic drugs receive gradual dose reductions, drug holidays or behavioral programming, unless clinically contraindicated in an effort to discontinue these drugs.

JAGS 37:65–74, 1989

Tying Down the Elderly
A Review of the Literature on Physical Restraint

Lois K. Evans, DNSc, RN and Neville E. Strumpf, PhD, RN, FAAN

The apparently widespread practice of physical restraint of the elderly has received little systematic research, despite reported clinical awareness of its iatrogenic effects on frail elders. Prevalence rates in various settings range between 6% and 86%, with cognitive impairment an important risk factor for restraint. Despite strongly held beliefs, efficacy of restraints for safeguarding patients from injury has not been demonstrated clinically. This paper reviews the current status of knowledge regarding physical restraint use with the elderly and suggests a research agenda and implications for ethical practice. J Am Geriatr Soc 36:65–74, 1989

Assent, and you are sane;
Demur, — You're straightway dangerous,
And handled with a chain.
from "Much Madness is Divinist Sense,"
by Emily Dickinson, Book I, XI

Everyday in the United States over 500,000 older people in hospitals and nursing homes are tied to their beds and chairs. The practice of physical restraint, apparently adopted from psychiatry, is increasingly common in care of the elderly in nonpsychiatric settings. Despite a developing awareness of the physical, psychological, and ethical problems associated with the use of physical restraints with frail elders, the practice not only remains widespread, but appears to be accepted as inevitable. All 55 respondents to Schwartz'[1] recent inquiry about restraint use were supportive of attempts to develop alternative nursing management strategies; however only one-fifth of the respondents reported interventions they had tested or tried.[2] Whereas the problem of restraints has not been ignored in the literature, no attempt at systematic review, categorization, or conceptualization has been made, and before 1983, only one study directly related to the practice was published. A conventional literature search yielded mostly citations on auto safety equipment, restraint use in psychiatry, and devices for immobilizing research animals. To obtain a more comprehensive literature on restraint use, the authors traced reference lists from articles on falls, confusion, wandering, immobility, and functional status. The purposes of this paper are to review the state of knowledge regarding physical restraint use with the elderly and to suggest a research agenda and implications for safe and ethical practice.

Historical Perspective Physical restraints in various forms have for centuries been used to manage violent behavior, particularly in the mentally ill.[3] In recent decades, social pressure toward humanistic care and legal and regulatory efforts to protect the individual civil rights of psychiatric patients led to reduction, but not total elimination, of physical restraints with this population.

Currently, however, concern for the widespread practice of restraining elderly nonpsychiatric patients in hospitals and nursing homes has arisen. Precisely when restraints began to be used regularly with this group is unclear. As long ago as 1885, in an early nursing text, Weeks[4] cautioned "in violent delirium, restraint must be effectual or it only aggravates the trouble. . . . With proper attendance physical restraint is seldom necessary and should be avoided if possible . . . " (p. 302).

Newton's[5] text *Geriatric Nursing,* the first devoted solely to the care of the older patient, does not mention restraint use either in the section on care of "senile"

From the School of Nursing, University of Pennsylvania, Philadelphia, Pennsylvania.
Address correspondence and reprint requests to Dr Evans, School of Nursing, University of Pennsylvania, 420 Service Drive, Philadelphia, PA 19104-6096.

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patients or anywhere else in the text. Nonetheless by the end of the 1960s Gerdes[6] warned that restraints "seem to intensify the disorganized behavior of many patients. Extremely confused patients may misinterpret restraints as punitive. Restraints, in themselves, contribute to sensory deprivation and a loss of self-image" (pp. 1232–1233). Early in the 1970s Cubbin[7] spoke out against the overuse of restraints: "the effect of restraining many patients who are mentally well but physically poor can undoubtedly lead to a deterioration in the patient's mental condition" (p. 752). Miller[8] and Oster[9] spoke to the myriad adverse effects of restraints and immobilization. Covert et al[10] observed the frequency with which "any display of socially deviant behavior is met with physical or chemical restraints" (p. 85) in nursing homes. In the same year, Cornbleth[11] tested use of a protected environment as an alternative to physical restraint for wandering patients. By the end of the decade Burnside[12] recommended no restraints for patients with Alzheimer's disease.

Since 1980 the literature regarding restraint use with the elderly has increased markedly. Actual research on physical restraint is, however, sparse, even in the psychiatric literature. With elderly nonpsychiatric patients only ten studies of physical restraints were found (see Table 1). These address the prevalence of physical restraint among hospitalized elderly;[13–16] nursing home prevalence[16] and restraint practices;[17,18] patients' reactions to being restrained;[19] and nurses' decisions to restrain elderly patients.[20] Further, two reports of interventions to decrease restraint use with the elderly were found in acute, continuing, and long-term care settings.[21,22]

INCIDENCE AND PREVALENCE OF RESTRAINT USE

The incidence and prevalence of restraint use in the elderly varies by setting and in relationship to the patient's age and cognitive status. In hospital settings, reported incidence of use of restraints varies from 7.4[15]–22%.[23] The first systematic survey of restraint use in four acute medical units over a 3.5-month period[15] revealed an overall 7.4% incidence of restraint. No observations were made during the period of lowest nurse staffing, ie, weekend, night, or late evening; thus, the authors note that the actual rates of use may have been higher. In a prospective study of restraint use among consecutive medical and surgical admissions to an acute care hospital, Robbins et al[14] found that restraints were applied to 17% of study patients over age 54. Warshaw et al[24] examined care of those over the age of 70 in a community hospital; body or arm restraints were prescribed for 19% of subjects. In a survey of the nursing needs of 87 patients over the age of 75 admitted to two randomly selected general medical wards, Mion, Frengley & Adams[23] found that 22% of elders were physically restrained. Others have documented similar prevalence rates for restraint use with hospitalized elderly in Canada[16,25] and the United States.[13,26–28]

The prevalence of restraint use in nursing homes is considerably higher than that in hospitals, reportedly between 25% and 84.6%. In the skilled nursing facility of one life care community, 25% of residents were restrained.[18] Likewise in the 1977 survey of American nursing home residents, 25% of 1,303,100 were restrained by a geriatric chair, cuffs, belt or similar device.[29] Farnsworth[17] reported a mailed questionnaire poll of restraint use in a random sample of 500 nursing homes; of the 183 respondents, 181 homes used restraints. In the late 1970s over 84.6% of residents in Canadian continuing care facilities had restraints in use; 92% used seatbelts and all had bedrails.[30] Dube and Mitchell[31] reported that 41% of their patients in a skilled nursing facility had restraint orders for vest or sheet restraints. While documenting the extent of behavioral problems in a random sample of skilled nursing facilities in upstate New York, Zimmer, Watson and Treat[32] found that restraints were used for 30% of residents.

The use of restraints has been shown to systematically increase in relationship to the age of the patient and the level of cognitive impairment, irrespective of setting. In their study of restraint use on four acute medical units, Frengley and Mion[15] showed that 56% of subjects who were restrained were aged 70 or older, and that those over 70 were significantly more likely to be restrained than younger patients; rates were 20.3% versus 2.9%. Robbins et al[14] found that while restraints were applied to 17% of medical and surgical study patients aged 54 to 95, those over the age of 70 were more likely to be restrained. Likewise, Appelbaum and Roth[13] found all restrained medical and surgical patients were aged 60 and over. The relationship of age to restraint use in nursing homes is less clear. Morrison et al[16] suggested, however, that restraints are more frequently used in the oldest patients in nursing homes.

Like Appelbaum and Roth,[13] most studies have documented the increased use of restraints in patients exhibiting cognitive or behavioral impairments. Robbins et al,[14] for example, report the following as predictors of restraint use: abnormal mental status, diagnosis of dementia, surgery, and presence of monitoring or treatment devices. Among admission variables, cognitive impairment was the only significant independent predictor of restraint in their study. Gillick et al[26] have suggested that age differences in the use of restraints in acute care hospitals disappear when the variable of cognitive status is controlled. In their study of adverse consequences of hospitalization in the elderly, older adults compared with their younger counterparts were equally at risk of being restrained when exhibiting confusion (52.9% *vs* 58.3%).

Almost all nursing home studies document increased

TABLE 1. SUMMARY OF STUDIES OF PHYSICAL RESTRAINT OF THE ELDERLY BY YEAR

Authors	Sample	Design	Prevalence	Type	Duration	Risk Factors	Rationale	Effects
Farnsworth[17] (1973)	Nursing home, random sample of 500 US homes (36.6% response rate)	Mailed questionnaire survey	Restraints used in 99% homes	Vest (76%) waist (75%) mitt (19%) wrist/ankle (12%)			Confused (90%) violent (49%) hyperactive (44%) injured/ill (30%)	
Cape[22] (1983)	Acute care in Canada/Britain	Comparison of prevalence in 2 countries; evaluation of 10-bed restraint-free environment	Restraint use in Canada greater by 8 : 1					Accident rate higher on units with greater use of restraint
Appelbaum & Roth[13] (1984)	Acute care, 14 med-surg patients	Descriptive: observations on daily rounds × 3–8 wks, chart review, patient interview	1.17 incidents per 100 patient days		1–21 days	Age over 60 ($\bar{x}$ 74); impaired mental status	Mental incompetence; treatment resistance	
Yarmesch & Sheafor[20] (1984)	Acute care and nursing home, 23 volunteer RNs	Exploratory: questionnaire with decision vignettes	89% decisions were to restrain				Protect patient or protect others, control behavior	
Mitchell-Pedersen et al[21] (1985)	Acute care, 180-bed medical department	Pre-post one sample, evaluation of effects of policy change on restraint use	T_1 = 1570/6 mo T_2 = 45/6 mo				Wandering, unsafe mobility, aggressiveness, interference with life support	97% reduction in restraint use, 26% reduction in chemical restraint use, no significant change in number of serious falls
Frengley & Mion[15] (1986)	Acute care, 1292 adults on 4 med units over 15-wk period	Descriptive: daily observations, chart reviews	Overall = 7.4%; > 70 y.o. = 20.3% vs 40–55 y.o. = 2.9%	Waist (33%) chest (26%) mitt (13%) multiple = common	1–13 days $\bar{x}$ = 2.7 days; $\bar{x}$ = 3.2 days for > 70 y.o.	Over age 70		Higher death rate; longer length of stay
Morrison et al[16] (1987)	Acute and extended care	Survey: record review	13.2% total	Jacket (AC) lapbelt (EC)		Older age; dx OBS, hospitalized in general medicine or neurology		
Robbins et al[14] (1987)	Acute care, random sample 137 med-surg patients ≥ 70 y.o. and 85 patients < 70 y.o.	Prospective: observation, chart review	18% ≥ 70 y.o. 14% < 70 y.o. total 17%	Wrist (72%) chest (51%) wrist (31%) $\bar{x}$2/patient	$\bar{x}$ = 3 days range = 1–35	Abnorm. mental status on admission; OBS; surgery; mobility restriction	Restless/agitation (38%), prevent pulling out tubes (22%), prevent wandering (3%), combined (16%), unclear (22%)	Longer length of stay, higher death rate, increased nursing home placement
Strumpf & Evans[18] (1987)	Nursing home, random sample 20 residents ($\bar{x}$ age 88.6) and 20 nursing staff	Descriptive exploratory: interview, observation, chart review, questionnaire	25%	Vest, geri-chair, mitt, wrist	$\bar{x}$ = 45 days in past 75-day period	Impaired physical function, impaired orientation	Prevent falls, altered mental status, other safety	Physical, behavioral, emotional
Strumpf & Evans[19] (1988)	Acute care, 20 medical patients and their 18 primary nurses	Descriptive exploratory: interview, chart review, questionnaire		Vest, soft limb, leather, geri-chair, mitt	$\bar{x}$ = 23.3 days		Prevent falls, safety, facilitate medical treatment	Behavioral, emotional, physical

restraint use in those patients exhibiting behavioral or cognitive impairment.[33,34] Zimmer, Watson and Treat,[32] for example, noted that restraints were used in nearly 50% of those residents in a skilled nursing facility found to have moderate or serious behavior problems. In the 1977 Survey of Nursing Home Residents, one third of the residents reported to be physically restrained were agitated, nervous, or hypertensive; 36% were abusive, aggressive, or disruptive; 43% were wanderers and 27% were withdrawn.[29] Evans[35] studied characteristics of nursing home residents who displayed sundown syndrome and found that sundowners were more than three times as likely to be physically restrained than non-sundowners.

Little prevalence data exists as to the type of physical restraints that are used in acute care hospitals and nursing homes. Only one study systematically assessed type of physical restraint. Robbins et al[14] found that multiple physical restraints were the rule with wrist restraints most commonly used, followed by chest or jacket restraints. Strumpf and Evans[19] reported higher use of the chest restraint, whereas Morrison et al[16] reported the chest restraint as most common on acute care units and the lap belt in extended care wards. Frengley and Mion[16] reported that the most common type was the waist restraint (especially for the elderly), followed by chest and wrist restraints. Three studies were found that documented periods of restraint ranging from 1–3 weeks,[13] 1–13 days,[15] and 1–35 days with a mean of 3 days.[14] In a study of 20 hospitalized restrained elderly patients, Strumpf and Evans[19] found the period of restraint ranged from 1–121 days (mean 23.3 days, median 11 days, mode 4 days).

RATIONALE FOR RESTRAINT USE

Prevention of injury to self or others is the most frequently cited rationale for the use of physical restraints.[13,15,19] To examine nurses' decision-making to restrain elderly patients in four medical-surgical and two nursing home units, Yarmesch and Sheafor[20] submitted four patient vignettes to 23 volunteer nurses. The vignettes described typical patient situations (wandering, pulling out tubes, agitation, confusion) and a range of frequently prescribed interventions. Of the total nursing care decisions made, 81 (89%) were to restrain the patient, and only 10 decisions were to withhold restraint and substitute alternative measures. More than half of the 149 reasons given to restrain were to protect the patient or others; the second most common reason was to control behavior.

No scientific basis of support yet exists for the efficacy of restraints in safeguarding patients from injury.[36] Regardless, as Robbins[37] acknowledges, restraints have certain appeal: an immediate impact on behavior, easy application without much training, ready accessibility, and administrative sanction. Appelbaum and Roth[13] reported an examination of involuntary treatment and restraint of older adults hospitalized on medical and surgical wards. "Incompetent patients" who refused treatment were often restrained or sedated and then treated, both without consent. Physical restraint was the most common intervention when a patient's behavior interfered with treatment or disrupted treatment of others.

Most authors concur that cognitively impaired elders are at greater risk for accidents, are less able to understand and cooperate with medical care regimens and may behave in ways that endanger or disturb other patients or staff. Physical restraint has been used to protect, facilitate treatment for, or control the brain failed patient.[13,20,24,26,32,38–45] Covert et al[10] notes that "prn" orders for restraint are not uncommon among nursing home patients where ". . . any display of socially deviant behavior is met with physical or chemical restraint" (p. 85). Rose[46] suggests that "some patient controls are designed to assure good body alignment rather than to restrain" (p. 21). Burnside[47] questions whether restraints might be used by nurses to punish patients or out of frustration. Insufficient staffing;[46] staff attitudes;[7] administrative pressures to avoid possible litigation;[30,36,48,49] or normative values[7,33] are also suggested as possible contributors to restraint use. Yarmesch and Sheafor's study[20] demonstrated nurses' readiness to restrain, and Frengley and Mion[15] documented that little discussion of decisions to restrain was generated among members of the health care team.

A British editorial[49] pointed to fear of litigation following patient injury due to falls as the most compelling reason for the increasing use of restraints for elderly patients in the United States. Evidence suggests, however, that risk of injury from falls out of bed increases when restraints are applied.[34,50–59] In general, the conclusions from most such reports indicate that restraint measures seldom eliminate the risk of injury. Feist[60] states that many patients learn to untie their restraints and that numerous falls, especially from wheelchairs, result from attempts to remove restraints. Finally, once a patient falls, regardless of outcome, the consequences often include some form of restraint or confinement. Although most accidents result in only minor injuries, nursing personnel are much more likely to restrain older than younger patients in the mistaken belief that the old will always seriously injure themselves.[61] Predictors of physical restraint are summarized in Table 2.

EFFECTS AND CONSEQUENCES

The apparent willingness of health professionals to apply restraints to the elderly is somewhat paradoxical in view of existing knowledge about the range of serious effects and consequences of restraint and immobilization in this age group. Warshaw et al[24] report that physical restraints reduce functional capacity as a patient

TABLE 2. PREDICTORS OF PHYSICAL RESTRAINT FOR ELDERS IN HOSPITALS AND NURSING HOMES

Patient factors	System factors
Age[13-16,23-28]	Administrative pressure to avoid litigation[30,36,48,49,77-80]
Cognitive impairments[10,11,13,14,20,24,26,29,32-35,38-43,97]	Availability of restraint devices[21,98-101]
Risk of injury to self or others[13,15,19,36,61,76]	Staff attitudes[7,47]
Physical frailty[7]	Insufficient staffing[44]
Presence of monitoring or treatment device[14]	
Need to promote body alignment[46]	

quickly loses steadiness and balance when restricted to a bed or chair. Devices that are too restrictive or too tight can cause problems of elimination,[30] aspiration pneumonia,[62] circulatory obstruction,[63] cardiac stress,[14] skin abrasions or breakdown,[6,44,64] poor appetite and dehydration,[6] and accidental death by strangulation.[22,25,31,40] In addition, an association between the use of physical restraints and death during hospitalization has been shown.[14,15,19]

Immobilization of the elderly patient by prolonged use of restraints can lead to many serious biochemical and physiologic effects. Abnormal changes in body chemistry, basal metabolic rate and blood volume, orthostatic hypotension, contractures, lower extremity edema and decubitus ulcers, decreased muscle mass and tone/strength, bone demineralization, overgrowth of opportunistic organisms, and EEG changes have been well-documented.[8,9,65] Further, animal studies indicate that physical restraint causes a stress response resulting in increased corticosterones[66] and decreased function of the blood brain barrier in the autonomic centers.[67] Perceptual and behavioral responses that have been noted with immobilization[8,9,68-71] lend support to these physiologic effects in humans and may account for the disorganized behavior noted among elderly restrained patients. Attempting to restrain a frightened, delirious patient serves to increase the panic and fear of danger that can produce angry, belligerent, or combative behavior.[40,62,72-74] Emotional desolation may result from fear of abandonment or embarrassment of incontinence.[14]

In one study,[19] 20 hospitalized elders were asked about the experience of being restrained and their responses were categorized. One patient stated, "If there was a fire, I'd be caught. . . . How would I get out?" (fear). Another said, "I felt like a dog and cried all night. It hurt me to have to be tied up" (demoralization). Other categories of responses were anger, resistance, humiliation, discomfort, resignation, and denial. Four patients gave responses indicating at least partial agreement with the use of restraints; one said, "If I hadn't been tied down I might have gotten off the bed and . . . fallen down."

Hiatt[75] stated that families often express dismay at the presence of geriatric tray tables and restraints in long-term care facilities. Straker[44] believes restrained elders feel humiliated or outraged and perceive that they are being treated as children without control or entitlement as adults. Several authors note, with elderly patients, that restraints precipitate regressive behavior, withdrawal, resistance, and agitation.[34,44,46] Further, the restrained patient may be viewed by others as disturbed, dangerous or mentally incompetent.[21] Table 3 summarizes potential benefits and risks of physical restraint of older adults.

LEGAL-ETHICAL DIMENSIONS

Despite lack of research evidence for the effectiveness of restraints in preventing injury, their use continues to be highly sanctioned in American hospitals and nursing homes. "Any nurse can apply as much restraint as is necessary to protect the patient from hurting himself or hurting anyone else"[76](p. 4). Creighton's[77] review of several legal cases and findings regarding bedrail use and accidents from 1950 to 1982 shows that over time,

TABLE 3. COMPARISON OF POTENTIAL BENEFITS AND RISKS OF PHYSICAL RESTRAINT OF ELDERLY PATIENTS

Potential benefits	Potential risks
Prevention of falls which might result in injury[19,76-78]	Injury from falls[34,50-59]
Protection from other accidents or injuries[19,76-78]	Accidental death by strangulation[22,25,31,40]
Allow medical treatment to proceed without patient interference[13,14,19]	Functional decline[24]
Aid in maintenance of body alignment[46]	Skin abrasions, breakdown[6,44,64]
Protection of other patients or staff from disturbances or physical harm[13,20,76]	Biochemical, physiologic and psychologic sequelae of prolonged immobilization[8,9,62-63,65,68-74]
Increased patient feeling of safety and security[19]	Cardiac stress[14]
	Reduced appetite, dehydration[6]
	Disorganized behavior[40,62,72-74]
	Emotional desolation[14,19,64]
	Possible increased mortality[14,15,19]

tion therapy, behavioral modification therapeutic touch, active listening, attention to feelings and concerns.[10,44,88,89] Physical and diversionary activities such as television, radio, music, recreation, exercise, ADL training, and physical and occupational therapy[90] are suggested. Administrative support to decrease staff fear of suit or other repercussions[30] is essential as is training and emotional support for staff who work with residents with behavioral disturbances to enable them to tolerate and respond appropriately to a broader range of potentially bothersome behavior.[91]

For wandering, the single problematic behavior for which there is a developing literature, "creative control" is viewed as better than restraint[92] and may take several forms: a locked or closed unit; door alarm systems;[11,73,93] recreational and social activity and exercise; programming changes, eg, nighttime activities for those who awaken and wander at night;[94] appropriate outlets for industrious or anxious behavior; sheltered courts and gardens with irregular spaces for exploring;[95] walking with, distracting and attending to patients' feelings and concerns;[88] and camouflage.[96] Hiatt[97] has noted that wandering is not as widespread as is the application of physical restraint in an effort to prevent it.

A change in policy and staff expectations coupled with removal of restraint equipment has been shown to decrease restraint use on certain types of units.[21,98–101] No studies were found that compared effects of alternatives to restraints, although Rubenstein et al[36] calls for such a study in relation to the efficacy of bedrails in preventing falls.

IMPLICATIONS FOR RESEARCH

Interest in issues surrounding the practice of restraining the elderly in hospitals and nursing homes has grown over the past 15 years. Evidence for reduction of physical restraint of the elderly exists in Great Britain[22] and Denmark;[32] acceptance of the practice in North America, however, remains widespread. Research aimed directly at describing and understanding the implications of this practice has only recently been published. Excluding the Farnsworth[17] nursing home poll, these studies have been reported since 1983.[13–16,18–22] The studies are descriptive and limited by sample size, selection, and the use of single institutions, usually acute care hospitals. Some suggest, but none definitively support, the iatrogenic physiologic or psychologic effects of restraint in a frail patient population. None have compared the effectiveness of physical restraint versus alternative interventions in relation to outcome measures. None have compared designs of the various products in terms of safety, comfort, or efficacy. Thus many gaps remain.

Building on this beginning descriptive work, several areas need to be explored. These include 1) describing patient and nurse subjective experiences regarding the use of physical restraint; 2) demonstrating short and long-term sequalae, both physical and psychological, of restraint; 3) improving the design of restraint products; 4) testing efficacy of alternatives to restraint for behavior management; and 5) determining ways in which the practice of restraint may gradually be limited to serious, short-term circumstances.

IMPLICATIONS FOR PRACTICE

The importance of an interdisciplinary team approach is underscored by the fact that the causes of behavior frequently precipitating restraint are often identifiable and treatable. The high incidence and prevalence data from nursing homes suggest inadequate adherence to published professional standards for application of a restraint. Although the patient's bill of rights, state and federal regulations, and institutional policies insure freedom from unnecessary restraint, practice is not always congruent with policy. Disagreement regarding what is "necessary restraint" points to a role for the patient/family and/or surrogate in any decision-making about restraint use. The role of advanced directives and informed consent in restraint use is a significant issue needing greater attention.

In making a decision about restraints, the goal of care must be thoughtfully weighed. The desired outcome for patients in acute care is generally cure or improvement in health through the use of sophisticated diagnostic and treatment measures. In long-term care settings, on the other hand, rehabilitation, maintenance of function, quality of life, and a dignified and comfortable death are the chief goals. Thus, the decision to apply a restraint, from a "burden versus benefit" point of view, might conceivably be justified in some situations and not in others (Table 3). The use of wrist restraints to facilitate a delirious patient's intravenous rehydration and possible return to normal cognitive status might be more justified than the same restraint applied to enable the long-term placement of a feeding tube in a severely cognitively impaired, physically deteriorated, and resistive elder. Thus, consideration of the anticipated length of time in restraint, goals of care, and the likely outcome for the patient become extremely important questions to answer in those instances where restraints are comtemplated or in use. More discussion of this matter is urgently needed. Further, more attention to staff education regarding selection of appropriate restraints by type and size and their proper application and monitoring seems warranted if restraint-related accidental injuries and deaths are to be avoided. Finally, nurses have an ethical duty to patients and families to explain the reason for the restraint, to gain informed consent when possible, to give clear expectations when restraint can be safely removed, to maintain a therapeutic relationship, and to facilitate discussion after removal of a restraint in regard to the experience and any associated anxieties.

With an increasingly frail aging population, situations where elders appear unsafe, uncooperative, or noncompliant with care will become commonplace. The need, therefore, to balance autonomy, patient safety, and quality of life will be essential. A remaining challenge in meeting this need for patient care is the development and testing of alternative measures to physical restraint.

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A Further Exploration of the Use of Physical Restraints in Hospitalized Patients

Lorraine C. Mion, RN, MSN,† J. Dermot Frengley, MB, ChB, MRCP,*†
Cheryl A. Jakovcic, RN, BSN,* and John A. Marino, MD*†*

Four hundred twenty-one consecutive patients admitted to an acute general medical ward and two acute rehabilitation medical wards were studied to compare the characteristics and outcomes of physically restrained patients and unrestrained patients. Restraints were used in 35 (13%) of the general medical patients and in 49 (34%) of the rehabilitation patients. The restrained general medical patients had higher mortality and morbidity rates than their unrestrained counterparts. Restrained patients had a higher prevalence of a psychiatric diagnosis, and major tranquilizers were used more than in their unrestrained counterparts in both settings. The general medical patients tended to have more than one type of restraint at a time, whereas the rehabilitation patients were restrained for longer proportions of their hospital stay. Thirty-three percent of the restrained patients whom we were able to interview expressed negative perceptions about the presence of the physical restraints. Moreover, it was found that the presence of cognitive and physical impairments were highly predictive of restraint use in both populations. J Am Geriatr Soc 37:949–956, 1989

The physical restraint of patients remains a common, but somewhat controversial, practice in the United States and Canada.[1–4] There is increasing awareness of a decidedly higher prevalence of the use of physical restraints in North American hospitals in comparison to hospitals in Europe.[1,4] Some evidence exists that the use of physical restraints is not a benign practice and is associated with adverse effects, such as longer length of hospitalization, higher mortality rates, higher rates of complications, and negative patient reactions.[5–8] Complications of falls and deaths as a direct result of physical restraints have been reported.[9–11] In acute psychiatric settings the prevalence of physical restraints ranged from 3.6% -5%[12,13]; in the long-term care settings it increased to 19%–85%[4,9,14]; whereas rates of 7.4%–17% have been reported on general medical and surgical floors.[5–7]

Studies of the use of physical restraints in other than psychiatric settings have been sparse. Management of violent or out-of-control behavior is the primary reason for the restraint of psychiatric patients.[12,13,15–18] On the other hand, violent behavior seems to be rarely observed in restrained patients in nonpsychiatric settings.[6,19] Indeed, it has been postulated that fear of litigation as a consequence of a patient fall is a primary factor in the use of physical restraints in these settings.[1,3,20–22] Paradoxically, concern for the individual's right to privacy and self-determination has resulted in legally limiting the use of physical restraints in psychiatric settings, and, more recently, guidelines for the use of physical restraints in nursing homes have been established.[13,14,23,24]

As yet there are no agreed upon guidelines for the use of physical restraints in general hospitals. Given the few published studies in the acute care setting and the possibility of adverse consequences of the use of physical restraints, a prospective exploratory study was conducted. The purposes of this study were to discover

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From *Cleveland Metropolitan General/Highland View Hospital and †Case Western Reserve University, Cleveland, Ohio.

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Address correspondence and reprint requests to J. Dermot Frengley, MD, Division of Restorative and Geriatric Medicine, Hamann Building 540, Cleveland Metropolitan General/Highland View Hospital, 3395 Scranton Road, Cleveland, OH 44109.

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those patient characteristics that increased the risk of the use of physical restraints, to confirm the association of physical restraint use with morbidity and mortality, and to determine the presence and nature of physicians' orders, the nurses' reasons for using restraints, and the patients' reactions to being restrained. These questions were asked of two different hospital populations, namely acute general medicine and medical rehabilitation, on the assumption that findings common to both populations were likely to be of greater importance than those variables found in only one.

METHODS

Setting and Subjects The study took place at Cleveland Metropolitan General/Highland View Hospital, a 715-bed county teaching hospital. One of three acute general medical wards (28 beds) and two of three acute rehabilitation medical wards (56 beds) agreed to participate in the study. The acute general medical service had a wide variety of typical medical conditions that required acute in-hospital treatment and management. Every patient admitted to the acute general medical service received an extensive history and physical examination by an intern, senior medical resident (PGY3), and, at times, a senior medical student. This information was recorded in the patient's medical record. Moreover, the patients were presented to an attending physician within 24 hours of admission. Notations of the patient's progress were made at least once a day by the medical and nursing staffs.

The rehabilitation medical wards admitted patients who continued to require daily medical management but could participate in an intensive rehabilitation therapy program.[25] These patients were recovering from a severely disabling illness, such as a stroke, or from debility following major surgical procedures. These wards were part of the medical house staff rotations and all patients had a detailed history and physical examination performed by a junior medical resident (PGY2) as well as by an attending internist. Moreover, the primary registered nurse, occupational therapist, and physical therapist documented the patient's physical and cognitive function on admission and throughout the hospital stay. This information was recorded in the patient's medical record.

All consecutive first admissions from April 7–June 30, 1986, to the general medical ward ($n = 278$) and from April 7–September 9, 1986, to the two rehabilitation medical wards ($n = 143$) were included in the study.

Data Collection Rounds were made daily, except for weekends and holidays by L. C. M. to the three wards to discuss with the nursing staff the physically restrained patients. Data on all restrained patients included information on the types of restraints, the physicians' orders, the duration of use, and the nurses' reasons for use and discontinuation of the physical restraint. Lastly, while the patients were restrained they were interviewed using an open-ended format questionnaire.

Chart audits were completed for all patients (restrained and unrestrained) by two of the authors (L. C. M. and J. D. F.). The patient characteristics included in this study were age, gender, marital status, race, admission source, and discharge disposition. Additional patient characteristics included the presence of a psychiatric diagnosis, the use of psychotropic medications, cognitive status, and physical functioning.

Cognitive status at admission and at discharge was obtained for all patients from chart audits and ranked as follows: 1 = comatose or stuporous; 2 = disoriented as to person, place, and time or oriented to person only, but inconsistent in following simple (level one) commands; 3 = oriented to person, and although following level one or simple commands, had obvious cognitive impairments noted in memory, calculation, and judgment; 4 = oriented to person and place but had impairments noted in memory, calculation, or judgment; 5 = oriented to person, place, and time, but had some mild cognitive impairment noted; and 6 = no cognitive impairments noted. The cognitive status of restrained patients was also assessed at the time of their interviews. This assigned ranking was verified by chart audit. Forty-three (10%) of the charts were randomly selected and audited separately by an independent investigator (C. A. J.). Inter-rater reliability in ranking the cognitive status was 0.90 and the weighted kappa coefficient was 0.74.

Physical function in 10 activities of daily living was evaluated at admission and at discharge with the Barthel Index, which ranges from 0 (total dependence) to 100 (total independence).[26] The concurrent and predictive validity based upon medical records, telephone interviews, and direct observations have been demonstrated for this index, as has the inter-rater reliability ($r > 0.90$).[27–29]

Morbidity was assessed by length of stay, hospital complications, and severity of illness. Complications were defined as any documented adverse events unrelated to the underlying disease states that occurred during the entire hospital stay. These were categorized by type, ie, falls, hospital-acquired infections, effects of immobilization (such as new decubiti), and adverse effects of medications and procedures. Because of the occurrence of patient transfers between the various services within the hospital, it was not possible to determine accurately the time sequence of hospital-acquired infections and restraint use. Therefore, all complications were treated as dichotomous variables and rated as present or absent.

The Severity of Illness Index was used to measure the degree of illness regardless of diagnosis for each patient

TABLE 2. COMPLICATIONS IN ACUTE GENERAL MEDICAL PATIENTS (n = 278)

Complication	Restrained (n = 35)	Unrestrained (n = 243)	P-Vaue
	n (%)	n (%)	
Falls	6 (17)	3 (1)	.001*
Immobility-Related	3 (9)	4 (2)	.045*
Nosocomial Infection	8 (23)	13 (5)	.001
Medication-Related	10 (29)	38 (16)	NS
Procedure-Related	2 (6)	19(8)	NS

NS = not significant.

* *Fisher's exact two-tail.*

tions (power = 0.64). Therefore, significant differences in these latter variables may have been masked by a Type II error.

Independent variables assessed on admission and included in the logistic regression analysis were the patient's age, gender (male = 0, female = 1), race (nonwhite = 0, white = 1), admission source (home = 0, other = 1), severity of illness category, physical function, cognitive status (decreased = 0, normal = 1), presence of a psychiatric diagnosis (absent = 0, present = 1), and use of a major tranquilizer (no = 0, yes = 1). The dependent variable was whether or not the patient was restrained at any time while on the study ward. Logistic regression analysis shown in Table 3 revealed that five variables were significantly related to the use of restraints in the general medical setting—namely, greater physical dependency, decreased cognitive status, increased severity of illness, presence of a psychiatric diagnosis, and race (white).

Restrained Patients Patients were restrained on an average of 4.5 days, with a range of 1 to 18 days. The proportion of the hospital stay in which they were restrained ranged from 0.06 to 1.0 (complete hospital stay) with an average of 0.48 (± 0.31).

Forty-three percent of the restrained patients had more than one type of restraint at a time with an average of 1.6 (± 0.8) restraints per patient. The most frequently used restraints were waist (57%), chest (40%), and soft wrist (40%). Other restraints included soft ankle (9%) and leather wrist and ankle (6%). The sum does not equal 100% since some patients had more than one type of restraint applied.

The nurses' reasons for using the physical restraints were to keep the patient from getting out of a bed or chair (71%); to maintain therapies, ie, prevent the disruption of tubes and dressings (34%); to manage wandering or hyperactivity (23%); to manage violent behavior (11%); to maintain the patient's sitting balance (11%); and to prevent the patient from self-harm (11%). More than one reason was given for using a physical restraint on sixteen (46%) of the patients.

All but one of the patients had cognitive impairments noted at the time of being restrained. Moreover, 28 (80%) of the restrained patients had a cognition level of 3 or below.

Documentation of the use of physical restraints was absent or sparse in 20 (57%) of the medical records. Ten (29%) of the general medical patients had a physician's order for physical restraints, three of which were specific to type, duration, and purpose. Documentation of alternatives to restraint use was also sparse and found in only seven (20%) of the records. Physical restraints tended to be in place for 16 to 24 hours a day (86% of the patients), with the highest use on day shift and the lowest at night. Apart from one patient who suffered abrasions, no direct complications were noted from the restraints. In 20 (57%) of the cases, the patient's condition changed, allowing for the removal of the physical restraint. These patients continued to require hospitalization for medical care. For the remainder of the patients, the restraints were maintained until they were discharged.

The patients' feelings and reactions to the physical restraints were obtained from 13 (37%) of the general medical patients while they were restrained. The remainder were either stuporous, aphasic, or too confused

TABLE 3. LOGISTIC REGRESSION OF RESTRAINT USE AMONG ACUTE MEDICAL PATIENTS (n = 278)

Variable	Coefficient	Standard Error	P-Value	Estimated Relative Risk*
Intercept	−5.37	1.73	.0019	
Severity of Illness	1.58	0.45	.0004	21
Admission Cognition	−2.70	0.80	.0007	16
Admission Barthel	−0.03	0.01	.0005	8
Race	2.02	0.77	.0082	7
Psychiatric Diagnosis	1.35	0.64	.0347	4

* *Each variable was assessed separately for contributing to the relative risk of being restrained assuming all other covariates had equal values. For severity of illness we calculated the risk based on severity of illness = 3, compared to severity of illness = 1; decreased cognition = 0, compared to normal cognition = 1; Barthel score = 20, compared to Barthel score = 90; white = 1, to nonwhite = 0; and presence of psychiatric diagnosis = 1, to no such diagnosis = 0.*

TABLE 4. COMPLICATIONS IN MEDICAL REHABILITATION PATIENTS ($n = 143$)

Complication	Restrained ($n = 49$)	Unrestrained ($n = 94$)	*P*-Vaue
	n (%)	n (%)	
Falls	28 (57)	18 (19)	.001
Immobility-Related	11 (22)	16 (17)	NS
Nosocomial Infection	29 (59)	31 (33)	.003
Medication-Related	11 (22)	16 (17)	NS
Procedure-Related	3 (6)	0 (0)	.039*

NS = not significant.

* *Fisher's exact two-tail.*

to respond. Three of these 13 patients were angry at being restrained while ten were indifferent or denied the presence of the restraint.

Medical Rehabilitation Patients

All Patients Forty-nine (34%) of the 143 patients admitted to the two rehabilitation wards were physically restrained at some point during their hospitalization. Little difference was noted in the average ages of the restrained and unrestrained groups (71.9 [± 11.2] *vs* 69.7 [± 11.9]). Twice as many men as women were restrained (67% *vs* 33%, $P = .001$, χ^2 test). There were no other significant demographic differences between the restrained and unrestrained patients. No significant differences were found in admission source and discharge disposition, but physically restrained patients had a greater tendency to be discharged to nursing homes (35% *vs* 13%).

More of the physically restrained patients than the unrestrained had a psychiatric diagnosis (35% *vs* 16%, $P = .011$, χ^2 test), received sedatives (18% *vs* 7%, $P = .049$, χ^2 test) or major tranquilizers (14% *vs* 0, $P < .001$, Fisher's exact test).

Barthel scores showed significantly lower physical function in the restrained group both at admission and at discharge (Admission: 18.9 [± 17.6] *vs* 41.4 [± 20.8], $P < .001$/Discharge: 45.5 [± 26.7] *vs* 71.0 [± 25.9], $P < .001$, Mann–Whitney test). Cognitive impairments were noted in all but one of the physically restrained patients at both admission and discharge. In contrast, the majority (63%) of unrestrained patients were noted to have no cognitive impairments ($P < .001$, Mann–Whitney test).

There was little difference in the average lengths of stay of the two groups. Eighty-three (58%) patients had at least one hospital complication, the most frequent being infections and falls. A higher proportion of the physically restrained patients fell, had a nosocomial infection (mostly urinary tract infections), or a complication following a procedure than the unrestrained patients, but not necessarily while restrained (Table 4).

Power analyses were calculated for all negative findings using an alpha = 0.05 and the actual data. The power values ranged from 0.75 (race) to 0.97 (marital status) with all items above 0.80 except for race and length of stay (power = 0.78).

Independent variables assessed on admission and included in the logistic regression analysis were the patient's age, gender, race, admission source, physical function, cognitive status, presence of a psychiatric diagnosis, and use of a major tranquilizer. The dependent variable was whether or not the patient was restrained at any time while on the study wards. Logistic regression revealed that only physical dependency, decreased cognitive status, and gender (male) were significantly related to the use of restraints in the rehabilitation setting (Table 5).

Restrained Patients Rehabilitation patients were restrained on an average of 29.8 days, with a range of 1 to 85 days. The proportion of the hospital stay in which they were restrained ranged from 0.02 to 1.0, with an average of 0.67 (± 0.35).

Seven (14%) of these patients had more than one type of restraint at a time, with an average of 1.2 (± 0.4) restraints. The waist restraint was by far the most frequently used (92%), while the other less frequently used restraints included lapboards (10%), soft wrist (8%), chest (4%), and mitts (2%). Eleven (22%) of the patients had more than one reason cited by the nurses for the restraint. The most frequently cited reason (67%) was to keep the patient in a bed or chair. Other reasons given were to maintain the patient's balance (33%); to manage

TABLE 5. LOGISTIC REGRESSION OF RESTRAINT USE AMONG ACUTE MEDICAL REHABILITATION PATIENTS ($n = 278$)

Variable	Coefficient	Standard Error	*P*-Value	Estimated Relative Risk*
Intercept	1.26	2.23	.5716	
Admission Barthel	−0.06	0.02	.0007	66
Admission Cognition	−4.06	1.16	.0005	49
Gender	−1.93	0.62	.0019	6

* *Each variable was assessed separately for contributing to the relative risk of being restrained assuming all other covariates had equal values. For physical function we calculated the risk based on a Barthel score of 20, compared to a score of 90; decreased cognition = 0, compared to normal cognition = 1; male = 0, compared to female = 1.*

wandering or hyperactivity (14%); to prevent the patient from self-harm (14%); to maintain therapies (8%); and to manage violent behavior (2%).

All but one of the restrained patients had cognitive impairments noted at the time of being restrained. Thirty-one (63%) had an impaired cognition level of 3 or below.

Physicians' orders were present in 26 (53%) of the charts, and none was specific as to type, duration, or purpose. Eleven (22%) patients had no documentation of the physical restraints anywhere in the records. Possible alternatives to the use of a restraint were noted in 12 (24%) of the records. Restraints tended to be in use for 16 to 24 hours a day (96% of the patients). All the patients were restrained on the day shift, but not necessarily on the other two shifts. Three patients suffered abrasions as a result of the physical restraints. No other direct complications were observed or noted. In 21 (43%) of the cases, the patient's condition changed, allowing for the removal of the physical restraint, while still requiring medical and rehabilitative therapy. For the remainder of the patients, the restraints were maintained until they were discharged.

Perceptions of the physical restraints were obtained from 29 (59%) of the rehabilitation patients while they were restrained. The most common reason for a lack of response was the presence of severe aphasia. Eight of the patients were angry or actively resistant to the restraints, seven denied the presence of a restraint, eight were compliant, three felt demoralized, and three were resigned to their use.

DISCUSSION

The use of physical restraints is a complex issue involving concerns about possible litigation, the patient's welfare and safety, and the success of therapeutic interventions, as well as the possibility of deleterious effects from the restraints themselves. This study, along with others, has attempted to understand further some of these issues. A limitation of this study design includes the possibility of interpretative bias among the chart reviewers, although a conscious effort was made to be objective in data extraction. Second, a Hawthorne effect may have occurred on the selected wards. We doubt, however, if the investigators' presence on the day shift or knowledge of the study significantly influenced the use of physical restraints. Lastly, it was not feasible to measure all clinically relevant information concerning the presence or absence of physical restraints, such as medication changes or the time sequence of complications and restraint use. With these limitations in mind, this study was undertaken to enhance understanding of the use of physical restraints. Two different medical settings were examined simultaneously to strengthen the generalizability of the results by delineating those elements common to both settings.

The study design thus incorporated two types of medical wards, acute general medical and acute rehabilitation medical wards, to compare patient characteristics and outcomes in relationship to the use of physical restraints. The results did show some differences in that fully one-third of the rehabilitation patients were physically restrained as compared to 13% of the general medical patients. On the general medical service the patients who were restrained were older than their unrestrained counterparts, a finding that has been supported in other studies.[5–7] This age difference was not apparent in the rehabilitation setting and was most likely the result of the presence of an already older population in this setting. Moreover, the age of the patient was not predictive of the use of physical restraints in either setting. There were proportionately more whites than nonwhites restrained on the general medical service, but no significant racial differences were apparent on the rehabilitation service. Conversely, gender had no effect on the general medical service, while men were restrained more often than women on the rehabilitation service. Given these conflicting results, it would appear doubtful that demographic characteristics of the patients, such as age, gender, and race, are important factors in the use of physical restraints.

General medical patients who were restrained evidenced greater morbidity than the unrestrained patients as shown by the higher nursing home discharges, longer length of stays, increased hospital complications, greater severity of illness, and greater cognitive and physical dysfunction. Rehabilitation patients who were restrained also tended to have greater morbidity when compared to unrestrained rehabilitation patients. In both settings, the physically restrained patients had a higher frequency of psychiatric illnesses and use of major tranquilizers than the unrestrained patients. It appears that chemical restraints were used in conjunction with physical restraints and not as alternatives. Nevertheless, only cognitive and physical impairments were predictive of physical restraint use in both settings. Furthermore, altered cognition has been implicated in other studies as a reason for the use of physical restraints.[6–8,34] Robbins et al[6] found in their study of hospitalized patients that cognitive impairment assessed on admission was the only independent predictor of restraint use with all other significant variables associated with the decrease in cognition. It would seem from our study, however, that regardless of age, those patients who demonstrate impaired cognition, poor judgment, or behavior disorders together with impaired physical function are those most likely to be physically restrained.

Types and purposes of physical restraints also differed somewhat between the two services. The rehabilitation patients were restrained for greater proportions of their hospital stay, with many of them restrained until discharge in contrast to the general medical patients. The greater use of restraints in this setting and the type of restraints perhaps reflected the decreased judgment and balance often manifested in these patients, particularly in those with a stroke.

On the other hand, the general medical patients usually had more than one type of physical restraint, more than one reason for their use, and a far higher mortality than their unrestrained counterparts. Although a cause and effect relationship cannot be shown, a high association did occur between the severity of illness and the use of physical restraints in the acute care setting. Indeed, the second most cited reason for the use of physical restraints on the acute care service was to maintain therapies (eg, prevent the patient from disrupting intravenous lines) as was also found by Robbins and colleagues.[6] It has been reported that attempts to prevent the disruption of medical therapy by the patient was often futile, and that consideration of an alternative medical therapy that would eliminate the need for physical restraints was usually lacking.[19]

Individual nurses vary in action and motivation for managing similar patient care problems.[35] Further evidence for this variation is shown in that the nurses did not consistently apply restraints from one shift to the next. It has been suggested that a low number of nursing personnel increases the likelihood of restraint use.[36] We found that the number of nursing personnel did not seem to influence the use of restraints since restraints were used more often during the day shift, the shift with the highest number of personnel. This high use of restraints during the day shift could be explained, however, by the fact that patients were more likely to be in a chair.

Indeed, the overriding concern for patient safety was evident in both setings in that the nurses' primary purpose for the restraint was to keep the patient in a bed or chair. The fear of litigation was spontaneously mentioned by several of the rehabilitation nurses but not by the general medical nurses. This dominance of the principle of safety may not be wise when a safe environment is achieved at the expense of other goals.[22,37]

Strumpf and Evans[8] hypothesized that nurses cope with the practice of restraining patients by believing that few alternatives exist to the use of the restraints. This suggestion is strengthened by our finding that there was consideration of an alternative to the use of a physical restraint for only 19 of the 84 restrained patients. This low occurrence, however, may be a reflection of a documentation problem. A lack of documentation has been reported in other studies.[1,6,8,37] At the time of this study it was hospital policy to have physician orders for physical restraints, yet they were often missing in both settings. Absence of physician orders was also found by Strumpf and Evans,[8] who indicated that the decision to use physical restraints was almost solely that of the nursing staff.

No direct serious physical complications from the use of physical restraints occurred in this study, but such outcomes have been reported elsewhere.[9,10,39] This lack of direct complications may have been a reflection of the conservative approach used to detect such occurrences. The study design did not allow for determining the possible sequelae of physical restraints separately from the many other factors affecting the patients.

The use of physical restraints has a detrimental effect on the psychosocial well-being of the patient.[8,14,37] Strumpf and Evans[8] found that the use of physical restraints caused conflict and uncertainty for most patients. In this study we, too, found similar results in that the interviewed patients primarily demonstrated denial and indifference (40%) or anger and demoralization (33%). Most of those who were angry were the rehabilitation patients. Indeed, the presence of physical restraints would seem to be less than optimal in fostering the patient's sense of recovery from an illness or preservation of normalcy during an illness.

Our major finding was that physical dependency and poor cognition were powerful predictors of a patient becoming restrained. The high severity of illness found in the restrained patients on the acute medical ward gives rise to concerns about the consequences of further immobilization produced by the physical restraints. Moreover, the high mortality rate among restrained patients on the acute medical service also raises questions regarding the quality and management of the end of life. The psychological distress found among the rehabilitation patients may well have impeded their progress in regaining independence. Further studies are still required to understand more clearly the decision to restrain a patient physically, as well as to determine if the beneficial effects of the physical restraints outweigh the deleterious effects on patient outcomes.

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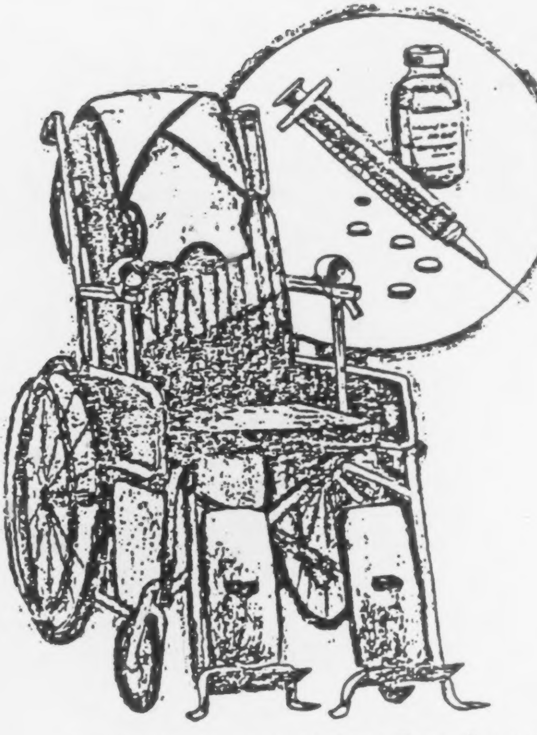
LET'S UNTIE THE ELDERLY

by

Lynne Mitchell-Pedersen
Lois Edmund
Elliot Fingerote
Colin Powell



St. Boniface General Hospital is an 850-bed tertiary care facility. The Department of Geriatric Medicine is a 188-bed area, including a 28-bed Palliative Care unit. Elderly people who are acutely ill, those who have been admitted for rehabilitation and those who are awaiting transfer to a personal care home comprise the patient population. Between December, 1981 and March, 1982 the Department of Geriatric Medicine changed its policy regarding the use of physical restraint. Within one year a 97% reduction in the use of physical restraint was achieved and this reduction has been maintained to the present. This article will describe the results of the policy change.

A "mechanical restraint" is defined as "a physical appliance that inhibits free physical movement". (Covert, A.B., Rodrigues, T. and Solomon, K., 1977). Included are limb restraints, mittens, wristlets, anklets, jackets and wheelchair restraints but not included are the use of geriatric chairs or siderails on beds. Chemical restraints are drugs "given with the specific and sole purpose of inhibiting a specific behaviour or movement." (Covert et al, p. 86-7).

The results of the change are shown in Table I. It is evident that the reduction in use of physcial restraints has been maintained. Two other issues emerge in discussing any reduction in use of physical restraint. Did the number of falls increase and was there an increase in the number of psychotropic drugs used? Table II shows the number of serious and non-serious falls before and after the policy change. "Serious" falls are those requiring medical intervention other than mere physical examination, for example putting in a suture. The increase in the number of serious falls is not statistically significant; it may well be clinically significant. A further study on falls has been undertaken to look at this problem.

There was no evidence that pharmacological restraint replaced physical restraint. Indeed, the use of psychotropic drugs was reduced by 26% in the January to June, 1982 period compared to the same period in 1981.

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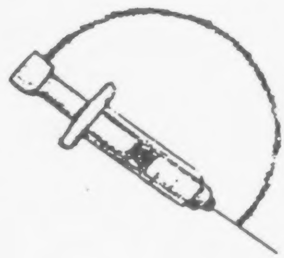
Questioning the use of physical restraints at St. Boniface arose from a tragic accident where a patient strangled in an improperly applied restraint jacket. The Hospital Board of Directors accepted recommendations from the inquest into the death. Firstly, a Registered Nurse must obtain a medical order for use of a physical restraint within fifteen minutes of its application. An R.N. must observe and document her observation of any restrained patient at least every fifteen minutes. Thus, the first step in the change process was that the use of restraints was made a little more difficult. Secondly, all staff were to be instructed in the proper use of restraints. A teaching videotape on how to restrain patients properly was developed and made mandatory viewing for all hospital staff.

However, the Department of Geriatric Medicine was challenged to look at a different question. Rather than learn how to tie people up could we learn other ways to care for them? The Department's Advisory Committee comprising of the managers of each discipline within the Department as well as all head nurses and physicians took up the challenge. It was recognized that a policy change in the use of restraints would have to be made with care. Four groups were identified for consideration in making such a change: patients, families, staff, and the institution itself.

Patients may react to being restrained in different ways. They may become agitated, fight and strike out at staff trying to tie them down. Anyone who has ever struggled to restrain a "resisting" patient remembers vividly the ensuing exhaustion for all. This involvement of time and energy should be remembered when the inevitable question arises, "But doesn't it take more staff to manage without the use of restraints?" Not all patients, however, will resist. Some may react passively and we see the familiar picture of the restrained patient, withdrawn, head on chest, dozing off to sleep. It must be remembered as well, that restraints affect how a patient is viewed by others. A restrained patient may be seen as being disturbed, dangerous or mentally incompetent.

Families too may react in various ways on finding their relative restrained. Initially, there may be shock and horror. Gradually however, they may come to accept the restraints believing that the restraints will keep the patient safe from wandering away or being hurt in a fall. Families generally accept professional advice particularly if safety was a concern before admission. Even if families have doubts about the use of restraints they may be reluctant to complain for fear of staff retaliation against their family member. However, usually when families understand that staff are trying to uphold the patient's dignity and right to be treated as an adult rather than as a child or a prisoner they usually support the controlled withdrawal of restraint.

Removing restraints from the patient induces tension in the staff. Fear of patient accidents, particularly falls and fear of being blamed for such accidents, underlies this tension. Although there is no evidence that restraints prevent falls it is nonetheless a commonly held belief.



Information about legal repercussions helped our staff make this change. Most important was the information (Cape, R.D., Dawson, D., Crawford, L. and Goodman B., 1979) that there has never been a lawsuit in Canada where an institution has been successfully sued for not using restraints. All lawsuits have involved the improper application of restraints. Indeed, further research by our hospital's legal advisors (Schwartz, McJannet, Weinberg, Riley, 1981) uncovered the information that the American courts, from whence much of the fear of legal reprisal spreads, upheld the notion that restraint use is undesirable. In two cases where institutions were sued for not using physical restraints on patients who ultimately did injure themselves the courts maintained that the institutions correctly did not use restraints and that such use would have impaired those patients' quality of life.

Assurance that legal repercussions against them were unlikely was coupled in our Department with the assurance of support from the medical staff in case of accidents. Such support was demonstrated in the concluding statement on an Incident Report signed by a physician after he had examined a patient who had fallen, "Old people will fall, you know!". While this support is reassuring to some it represents a shift in attitude for others. Staff had to be assured that everyone in the treatment team who read Incident Reports endorsed as good practice the non-use of physical restraint. Other feelings then gradually surfaced especially feelings of guilt at having tied up old people. Staff became highly creative at looking after patients without the use of restraints and feelings of pride developed as they were able to provide care that honoured the autonomy of their patients.

The tension for the institution lies in its need to maintain its reputation as a humane provider of care and to uphold its legal responsibility to care safely for its patients. Initially there was concern that the institution would be sued for some accident where a patient had injured himself and had not been restrained. Our legal advisors made it clear that, on the contrary, an institution should fear being left open to the tort of false imprisonment and of assault for using restraints without a patient's consent. Thus a very different light was cast on the use of physical restraint.

To determine how to reduce restraint use the Advisory Committee divided into study groups to discuss how to care for patients whom we might formerly have restrained. Four stereotypes, the "wandering, mentally - impaired person", "the unsafely mobile person", "the aggressive patient" and "the patient who interferes with life - support", were examined and medical, environmental and behavioural alternatives to using restraints for each group were identified. A teaching videotape was developed using staff and patients throughout the Department thus enhancing the sense of participation in the change process.

"So what else do you use instead of restraints?", is a question frequently asked. The answer is that there are no recipes for other ways to manage. The study groups concluded that the only answers lay in a thorough, multidisciplinary assessment of any given patient. The problem for which restraints might have been considered a solution must be identified before other ways to care can be substituted.

A few examples of how staff cared for patients without the use of restraints might be useful.

The Wandering, Mentally Impaired Person

Case 1: A 60 year old "wandering" patient with Alzheimer's Disease caused frequent disruptions at meal time when he stole food from other patients' plates causing great agitation. He had frequently been restrained because of this "disruptive" behaviour. When we asked, "Could he be hungry?" and doubled his calorie intake he stopped stealing food! What became clear was how little we know about behaviour exhibited by wanderers. Perhaps we might have asked our nutritionist to determine his calorie requirements. Wanderers' usually thin bodies suggest large energy expenditures. In this case it was his diet that needed attention; restraints compounded the problem.

There are no definitive answers as to how to care for wandering patients. Around the world staff are experimenting with environments that allow the wanderer to roam freely yet safely. Wallpaper over doors so that the door has the appearance of just another wall has apparently worked in some cases. A full length mirror may serve as a distractor to divert the wanderer's course. The relationship between a planned daily exercise program and the wandering behaviour has yet to be examined. Broad-based rocking chairs in place of straight-backed chairs may help to lessen a wanderer's agitation by supporting his ceaseless need to move. The ideal solution appears to be an attractive environment with paths for safe wandering. Not all of us can alter our institutions to meet this need but we might perhaps take some small steps toward this goal in attending to areas of the environment that may add to the wanderer's restlessness. For example, messages from a public address system may add to the wanderer's agitation. As well wanderers must have their drug regimens assessed carefully to ensure that the medications used are not contributing to the wandering behaviour.

Staff often need encouragement in caring for the mentally impaired wandering patient. It can be discouraging to try to be creative day after day with no apparent results. As well this patient is usually cared for in a setting that places many demands all at once on the carers and the frustration of "watching the wanderer" may become very stressful. Rewards in caring for this patient are different from those resulting from caring for someone who is alert and oriented. Rewards for the nurse come from understanding how the wanderer responds best to direction. For example, does he respond most easily to verbal or non-verbal suggestion? However, little information is available to the nurse and the nurse's trial and error approaches can be wearisome if prolonged. As clinical research identifies useful nursing interventions perhaps nurses will find support for their efforts.

The Unsafely Mobile Patient

Case 2: An 83-year old man with Parkinson's Disease injured himself frequently because in his desire for independence he would go to the bathroom and literally pitch himself onto the toilet frequently banging his head on the sink on one side or on the handrail on the other. In this case, rather than restraining the patient so that he would not move without supervision, staff identified the greatest risk and looked at how to reduce that risk. Nurses enlisted the help of the housekeeping department to hook foam pads on the walls behind the toilet and on the edge of the sink nearest the toilets. The pads were easily changed for laundering and the patient's independence no longer presented a safety hazard.

Case 3: Advice was sought from another institution about how to care for an 85 year old woman who was restrained in a chair because staff feared she would wander off and fall down the stairs at the end of the hall. The patient was assessed by a physiotherapist, had sturdy track shoes with rubber soles substituted for her bedroom slippers and was pronounced safe to manage the stairs. She was thus allowed to wander at will throughout the building.

This story illustrates the dilemma that often occurs when the unsafely mobile person has cognitive impairment as well. In this case the two issues (the wandering and the fear that she might fall) had to be dealt with separately.

The issue in caring for the unsafely mobile patient is whether it is more important for the patient to be autonomous and risk injury or is his safety of paramount concern. The physician's diagnosis is central here. We must know why this patient is unsafe, that is, why he is falling. Once the reason for the fall-re·strain ‘ri-’stran/ 1a: to prevent from doing, exhibiting or expressing something b: to limit, restrict or keep under control 2: to moderate or limit the force, effect, development or full exercise of 3: to deprive of liberty; *esp:* to place under arrest or restraint

ing is identified then plans can be made either to prevent falls or to reduce the risk of injury from falling. As well the doctor must check whether the patient's drugs are in any way contributing to the unsteadiness. The height of a bed is often a problem as it is difficult in Canada to obtain beds low enough for the patient to be able to place feet flat on the floor before standing up. A care plan that looks at environment through every step of the patient's day needs to be established. His routines for rising, toileting, exercising and socializing must be identified and the environment arranged to eliminate his need to move without supervision. Callbells within easy reach, remote control for T.V., bedside table close to bed or chair, bed kept in low position, siderails down can all help to prevent his trying to move without someone near. It goes without saying that the patient and his family must be included in this analysis and planning.

Equipment may prove a hazard to the unsafely mobile patient. Wheelchairs should be used for transportation not for seating. Wheels may be removed from beds and bedside tables to prevent their scooting away when the patient leans on them for support. Bathrooms may be equipped with rails and raised toilet seats to facilitate safe transfers. Attention to lighting so that the patient is not moving suddenly from a brightly lit to a darkened area is important as are night lights to guide trips to the bathroom. Attention to footwear is essential. Track shoes with rubber soles may be helpful for some. However, patients who shuffle need shoes that support properly but that allow the foot to slide easily along the floor.

Thus, caring for the unsafely mobile patient rests on a proper medical diagnosis and management as well as on detailed attention to the patient's environment.

The Aggressive Patient

Case 4: The story of a 78 year old man who swore violently and frequently struck out physically at the nurses provides an example of how an aggressive patient was managed without the use of restraints. An analysis of his behaviour identified that such reactions occurred when he was being transferred from his bed to a wheelchair or from wheelchair to toilet. Three concerns were identified. Firstly, he experienced great pain during the move. His pain medication was reviewed and his analgesic was timed for one half-hour prior to his planned moves of the day. Secondly, the physiotherapist was consulted to help staff move him with the least discomfort. Thirdly, it was realized that having the orderly help him move was very upsetting to him and provoked much of the swearing. He said later that it was humiliating to him to have another man see him tended by women. The physiotherapist was able to help the female nurses plan his move so that none was at risk of injury. The aggressive behaviour, both physical and verbal, ceased.

Aggressive behaviour is undoubtedly upsetting for the patient, his family, other patients and staff. Such behaviour cannot be ignored because of the potential for serious injury. Our experience has been that if we are able to identify patterns of behaviour then we are more easily able to treat the cause. We need to look at the patient's condition, physically, mentally and socially, at the time the behaviour took place. Does this patient have a history of aggressive behaviour? What events led up to the behaviour? What are the consequences or results of the behaviour? How does the patient describe the problem?

Involve the patient in the solution. Staff are ethically bound to choose the least restrictive approach available to cope with the behaviour. Restraints would therefore be a last choice, not least because restraining an aggressive patient usually increases his aggression.

Alternatives to the use of restraints for the patient behaving aggressively would consider interpersonal, environmental and medical measures. Nurses may need to spend time with the patient to identify what is causing such behaviour. Does he feel frustrated and see no way to express his frustration? Is he bored? Has he always solved problems by behaving aggressively? Many patients react aggressively when they feel they have lost control. Often, simply introducing choices such as when to do grooming activities, or where to eat the next meal, gives the patient a small sense of having choice in this restricted world and helps to reduce his agitation. Occasionally, distraction at the beginning of a series of behaviours leading up to aggression may avert the aggressive behaviour.

It is important to identify the people nearby in the event of aggressive behaviour. For example, is a fight in the Day Room predictable because of the patients who have been placed close together? Often a chain reaction occurs when one patient responds with fear or anger to gestures or words from another. A change in circumstances, such as relocation of people, furniture or time schedules, may take care of the problem.

We are sometimes reluctant to reinforce the negative consequences of aggressive behaviour by having the person responsible pay for damaged property, apologize to people who have been inconvenienced or clean up any mess. Sometimes to make clear the relationship between behaviour and consequences can be helpful. Again, the physician must review both diagnosis and drugs to ensure that the behaviour is not induced by treatment.

Interference with Life Support

Case 5: The next story shows how the nurse assessed the reason for a patient's behaviour before trying to control it. A 73 year old man with chest tubes in place because of a collapsed lobe in his right lung and pneumonia periodically became very agitated and tried to rip off his dressing and pull out his chest tubes. As well, he frequently yelled and struck out at the nurses when they tried to keep his hands away from the tubing. The nurses identified that his periods of agitation were intermittent and that he seemed to be lucid between these bouts. Conversation with him during the lucid moments revealed that he was experiencing hallucinations; he saw two little people who were coming to pull out his tubes. His terror led him to strike out at these two little people to drive them away.

The physician identified that the disturbing mental images may have resulted from oxygen deprivation due to the lung problems. Once the nurses understood that the hallucinations were at the root of the aggressive behaviour they learned to "talk him through" the periods of disturbance. The use of restraints would undoubtedly have increased his agitation. The patient's relief at having his behaviour explained to him was enormous, "Thank God you told me: I thought I was going crazy!"

Case 6: An 87 year old woman who was severely demented fell and broke her hip. She was in traction for a period of six weeks, during which time the nurses had a great deal of difficulty to stop her from pulling out her Foley catheter. The catheter was deemed necessary as her incontinence proved difficult to manage and her surgical dressing was in danger of being soaked at every voiding. The nurses identified that when they gave her soft sponges to squeeze in her hands some of her agitated hand movements seemed to diminish and she was less likely to pull at her catheter. The sponges were easily laundered in a net bag and prevented the need to restrain her wrists.

Patients who interfere with their life supports tax the creativity of the health care team. The key may sometimes rest in a clear identification of the reason for treatment. Sometimes a less intrusive treatment may be substituted. As well, it must be remembered that the patient's consent for the possible imposition of restraint must be considered. Sometimes control of pain or anxiety is the issue. Again, close monitoring of drugs and other treatments by the physician are essential.

Conclusion

Most health care workers agree that they would like to reduce the use of physical restraints in caring for their elderly patients. There is unanimous agreement that the practice should be stopped before we become old! It will only cease as all of us struggle with the issues involved and deliberately seek other ways to care. Let us hope that soon North American institutions will join the rest of the world in regarding the use of restraints as an outdated procedure and we will all untie the elderly! ○

TABLE I

Numbers of Mechanical Restraints Used in the
Department of Geriatric Medicine
St. Boniface General Hospital

January-June '81	January-June '82	January-June '83	January-June '84
1570	57	48	45

TABLE II

Falls - Department of Geriatric Medicine

January-June	Non-Serious	Serious
1980	214	8
1981	166	3
1982*	280	8
1983	314	6
1984	241	7

*change occurred

See text for definitions of "non-serious" and "serious"

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This article is based on a workshop given to Region 9 O.A.H.A. members in May, 1985 by Lynne Mitchell-Pedersen. Ms. Mitchell-Pedersen, R.N., M.Ed., is a clinical nurse specialist on the geriatric nursing staff of St. Boniface General Hospital, Winnipeg, Manitoba. Co-authors of this article include: Lois Edmund, Ph.D., formerly a clinical psychologist at St. Boniface and now teaching psychology at the University of Winnipeg; Elliot Fingerote, M.Sc. (Pharm.), formerly a clinical pharmacist at St. Boniface and now Director of Pharmacy at Deer Lodge Centre, Winnipeg; and Dr. Colin Powell, M.B., F.R.C.P. (Edin.), Head of the Department of Geriatric Medicine at St. Boniface General Hospital.

Legal Pulse

by Lori Costa

Residents' Rights and the Use of Restraints Under OBRA

How the new OBRA residents' rights provision will impact the use of physical and chemical restraints in LTC facilities.

In addition to the controversy concerning psychotropic drugs and their use as chemical restraints, OBRA '87 and subsequent draft regulations and guidelines have raised the issue of whether anything that restricts a patient's movement can be considered a restraint for purposes of compliance with the act's residents' rights provisions.

A restraint is defined as that which confines, restricts liberty or prohibits actions. This definition would appear to include such common devices used in long-term care facilities as a bedrail, geri chair, wheelchair, safety bar, helmet and postural supports.

Restraints Under OBRA. The Omnibus Budget Reconciliation Act of 1987 residents' rights provision regarding restraints states that the resident has "the right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms."

It further states that "restraints may only be imposed to ensure the physical safety of the resident or other residents, and only upon the written order of a physician that specifies the duration and the circumstances under which the restraints are to be used (except in emergency circumstances which are to be specified by the Secretary) until such an order could reasonably be obtained."

The OBRA provision is consistent with the broad definition of restraint in that it specifically speaks to the "restraints being utilized to ensure the physical safety of the resident or other residents." This provision is a departure from some state regulations, which have differentiated between physical restraints and nursing intervention devices utilized for the resident's safety and/or positioning. These regulations generally define physical restraints as being used to "control a resident's behavior." Conversely, a postural support is generally defined in terms of a care objective, which is defined as "proper body alignment," "fall prevention," etc.

In a Wisconsin case based on such a state statute, in which a resident sustained injuries because of a fall from a wheelchair, a decision for the plaintiff was overturned on appeal because of the failure to provide expert testimony concerning the standard of care for the prevention of falls and proper positioning. The court held that restraint used for some purpose other than behavior modification was not physical restraint based on the statute. (*Kujasui v. Arbor View Health Care Center*).

Most Common Injury. Staff shortages, fear of injury to residents and the potential for litigation could lead health care personnel to utilize restrictive measures inappropriately and compromise the mobility of residents. The most common resident injury in this area is falls, which often generate litigation based on negligence cause of action.

Not as frequent, except in the area of mental health, is litigation based on the intentional tort of false imprisonment. This basis of liability occurs when an individual's freedom is consciously restricted without the individual's authorization or consent, or there being any privilege. The confinement must be intentional and without any legal justification. OBRA's concentration on residents' rights could lead to more lawsuits filed in the whole area of intentional torts.

Emergency Circumstances. Perhaps the most troubling issue raised by this OBRA provision is the definition of emergency circumstances, which is to be made by the Health Care Financing Administration (HCFA), and will appear in either regulations or guidelines. Generally, an emergency is an unanticipated situation in which there is immediate danger; whether there actually is danger depends on the circumstances at the moment of the incident. It is troublesome that OBRA calls for finite parameters to be developed for emergency circumstances and places a restriction on the utilization of nursing judgment. Whether that can be implemented remains to be seen.

If a nursing facility and/or the nurse is to be held liable for the use of restraints, safety or positioning devices, the comprehensiveness of the nursing assessment of the resident's potential for injury to himself or others will be a critical element in the case. The assessment should include the identification of and the reasons for behavioral or medical deficits; whether the cause of the behavioral or medical conditions can be treated; alternate nursing interventions other than restraints for coping with the conditions; and the amount of risk to the resident and others in the facility.

In addition, nursing interventions must be evaluated on a regular basis to determine their effectiveness. Documentation must show that patterns of the resident's signs, symptoms and behavior are identified, and that individualized adaptations in the care plan are communicated to and carried out by the nursing staff. If restraints are used, the documentation should specify the type employed; the reason for, manner and time of their application; and other interventions that may have been tried unsuccessfully and the reasons they were not viable. The documentation should also show the continued monitoring and reassessment of the resident.

Nurses who work with geriatric residents must be continually aware that the use of a restraint doesn't eliminate the need for observation, it increases that need. Nurses have a duty to protect the health, safety and welfare of the resident, but they must also be aware of the resident's right not to be confined except for valid reasons. **CLTC**

Lori Costa, R.N., M.A., J.D., is a former long-term care nurse and state surveyor. She is licensed to practice law in California and currently maintains a health care consulting practice in that state.

Standards of Medical Care Based on Consensus Rather Than Evidence: The Case of Routine Bedrail Use for the Elderly

by Howard S. Rubenstein, M.D., Frances H. Miller, J.D., Sholem Postel, M.D.,
and Hilda B. Evans, R.N.

> *"An 88-year-old male patient was found on his hands and knees on the floor beside his bed. The bedrails were up." — From an incident report filed by a nurse at the Stillman Infirmary, University Health Services, Harvard University, in May 1980.*

Finding elderly patients lying on the floor beside their beds despite the presence of elevated bedrails seems paradoxical: how can a patient fall out of bed when the bedrails are up? Surprisingly, this paradox constitutes one of the leading incidents plaguing hospitals in the United States today.[1] It exemplifies a much larger problem created, we believe, by the uncritical adoption of measures designed to enhance patient welfare, but which may in fact undermine it. This article documents our experience with bedrails, reviews the literature, and comments on the rationale for routine adoption of bedrails for the hospitalized elderly. It concludes by advocating that a randomized, controlled study be conducted to determine whether bedrails constitute protection or a hazard to the average elderly patient.

Findings at the University Health Services, Harvard University

At the Harvard University Health Services, which has a predominantly young adult patient population, 34 of the 58 consecutive incidents (59 percent) that took place over an almost two-year period were slips and falls. Sixteen of the 34 "slip or fall" incidents (47 percent) involved patients falling while getting out of bed (GOOB). Of the 16 GOOB incidents, 12 of them (75 percent) involved patients aged 60 years or over (Table 1).[2] Beds were in the low position and bedrails were elevated in 14 (88 percent) of the GOOB incidents. Bedrails are routinely used for all patients aged 65 years and over and for most patients between ages 60 and 65. They are not routinely used for younger patients.

As far as could be ascertained, purposeful activity rather than sedating medicine, time of day, or disorientation of the patient seemed to be associated with the incident. The patient usually fell while climbing over the bedrails in an effort to reach the bathroom. Of the 16 GOOB incidents, purposeful activity was described in six of them. In 5 of the incidents, the nurse on her own initiative recorded that the patient's stated purpose in climbing over the bedrails was to reach the bathroom or commode. In the sixth, a 19-year-old climbed over the bedrails "just to see if I could do it!" In the remaining ten incidents, no reason for the fall was given in the incident report. This was not because the nurse did not answer a checklist item on the incident report, but because there was no such item requesting information about patient's stated purpose for getting out of bed on the incident form provided by the Risk Management Foundation of the Harvard Medical Institutions. Finding purposeful activity in one-third of the cases, therefore, was unexpected and especially meaningful because that information was only provided voluntarily by the nurses. We consider this a marked deficiency in the form used, and we recommend that in the future all incident report forms include "Purpose of GOOB" as a checklist item so that there is more complete information about the reasons why patients climb over bedrails.

Sedating medicine given to a patient within 6 hours of a fall was not associated with any group of incidents (Table 2). Other investigators have reported that antecedent sedating medicine contributed to 5 percent or less of falls by the elderly.[1] We did not anticipate this finding, and lawyers may be particularly surprised by it, since many malpractice cases, irrespective of the patient's age, concern falls in situations where antecedent sedating medicine was given and bedrails were not used.[4] The cases which come to a lawyer's attention may simply not be representative of all patients who fall while getting out of bed. Table 2 also shows that even in cases wherein antecedent sedating med-

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Dr. Rubenstein is Physician and Chief of the Allergy Clinic at University Health Services at Harvard University in Cambridge, Massachusetts. Ms. Miller is Professor of Law at Boston University School of Law, in Boston, Massachusetts. Dr. Postel is Deputy Director, Chief of Professional Services, and Chief of Medicine at University Health Services of Harvard University. Ms. Evans is Supervisor of the Inpatient Nursing Service, Stillman Infirmary, at University Health Services of Harvard University. The authors greatly appreciate the assistance provided by the Committee on Quality Assurance and Utilization Review at Harvard's University Health Services; Judith S. Rubenstein, Ed.D., educational consultant; and the nurses of Stillman Infirmary.

icine was given and bedrails were used in accordance with customary practice, bedrails did not prevent all falls. (Whether bedrails *should* in fact be used routinely for patients who have received lightly sedating medicine is an important question beyond the scope of this article.)

Although our patient population was predominantly young, and thus bedrails were not in common use, those who slipped and fell while getting out of bed were predominantly old and were routinely "constrained" by bedrails. This indicates that the problem primarily affects the elderly and furthermore suggests that bedrails seem to be associated with the falls, a finding in agreement with the reports of others.[5] How does it happen that bedrails are routinely used in the United States in the care of the hospitalized elderly despite a lack of scientific evidence that they protect, and in spite of abundant suggestive evidence that they may be hazardous?

The Law in the United States

The routine use of bedrails in the United States may stem more from a general fear of liability than from individualized determinations of their usefulness for particular patients. Lawyers, no less than physicians and others concerned with patient safety, seem to find it difficult to believe that something meant to protect may have no safety value at all and may even be hazardous.

Medical malpractice involves the failure to meet professional standards of care.[6] Today, medical standards are established by expert witnesses testifying about what a reasonable and prudent medical professional would do under circumstances similar to those at issue in a particular lawsuit. Using bedrails routinely for the elderly is something which "reasonable and prudent" medical professionals might do to protect their patients — if they had no evidence to the contrary. The law does not always distinguish between a standard based upon scientific evidence and a standard that is merely cultural, i.e., a "standard of consensus." The distinction can be critical, however. To alert the legal profession as well as the medical profession to the necessity for making that distinction is one of the principal purposes of this article.

In 1957, Ludlam, an attorney, wrote that bedrails demonstrate that "the hospital has made an effort to protect" the patient, and that the "judge and jury are . . . impressed by this effort."[7] In 1975, another lawyer wrote that "the accident which befalls [an elderly] person will most likely be charged to inadequate care or lack of safeguards. . . . The classic malpractice cases against hospitals [include] . . . falls from bed because of lack of siderails. . . . The nurse seems to bear the brunt of [such] accident claims."[8] Some physicians, either sensitive to such commentary or independently sharing similar beliefs, appear to have uncritically assumed this defensive legal posture. They have attributed great value to an untested measure, and thereby placed a heavy burden on the shoulders of nurses. For example, in 1958, two physicians, Weil and Parrish, wrote: "[N]urses . . . are able to prevent accidents. For example, to prevent falls from bed . . . it is [the nurses'] responsibility to see that bedrails are securely fastened. . . ."[9]

Ludlam reported the finding of the Council on Insurance of the California Hospital Association for the year 1954 — a time, he complained, when bedrails were not routinely used for the elderly.[10] Among the 120 member hospitals, there were 7,822 GOOB incidents in which the position of the bedrails was known: in 4,893 cases, or almost two-thirds of them, the bedrails were up. Ludlam did not suggest that bedrails might be contributing to the falls. Instead, he took a defensive position and advised: "It is much easier to defend or settle a case when the rails are up than when they are down."[11] He thus implicitly advocated the practice of defensive rather than preventive medicine. Defensive medical care does not necessarily serve the patient because it is intended primarily to build a record to protect the health care provider against a charge of malpractice.

The conflict between an observation on the one hand and the practice of defensive medicine on the other was well expressed in 1965:

> The value of siderails in preventing falls is debatable. . . . To many conscious patients, siderails are frightening and imply dangerous illness. To others, siderails are irritating and humiliating because they emphasize the confining aspects of hospitalization. Siderails also increase the height from which the patient falls when he goes over the rails. Nonetheless, when such cases come to litigation, awards or settlements are less expensive when it can be proven that the siderails were up.[12]

Most investigators, however, did not even suggest that raised bedrails might be contributing to the falls. Instead, they usually expressed the view that bedrails were necessary but not sufficient to protect patients. Thus, they suggested supplementing bedrails with yet additional "protective" measures — restraints,[13] better designed rails,[14] constant nursing supervision, either by spe-

Table 1

Nature of Incident vs. Age

Age	GOOB	NGOOB	NSF	
< 60	4	12	17	33 (56.9%)
≥ 60	12	6	7	25 (43.1%)
	16 (27.6%)	18 (31.0%)	24 (41.4%)	58 (100%)

$X^2 = 9.24$ with 2 degrees of freedom $p < 0.01$ (statistically significant)

Key: The groups are comparison groups:

GOOB : "Getting out of bed" slip and fall

NGOOB: "Not getting out of bed" slip and fall (e.g., a fall in the bathroom)

NSF: Non-slip and fall (e.g., a medication error) cial duty nurses[15] or by large open wards,[16] high (standard) beds with half-length rails,[17] and low (adjustable) beds with half-length rails.[18] Some believed that the problem lay not with the standard high beds or the bedrails, but with the personality of elderly patients who were described in some instances as "hostile,"[19] and in others as "disobedient."[20] Only Watkins and Robson, describing their experience in England, concluded unequivocally that bedrails were as hazardous as the standard high beds, and advised abandoning both in favor of low, adjustable beds without rails.[21]

Malpractice Claims

The National Association of Insurance Commissioners has reported[22] that falls represented 10 percent of all claims paid for medical malpractice during the three years between July 1, 1975, and June 30, 1978. Of those falls, 87 percent occurred in hospitals, and about half of these occurred in the patient's room. The two reasons given most frequently for claims paid for falls were "improper protection of the patient" and "no side rails." Significantly, there was no category at all for claims paid because bedrails were used inappropriately or without indication. These were never even identified as legitimate situations wherein settlement might be appropriate.

The routine use of bedrails may stem more from general fear of liability than from individualized determinations of their usefulness for particular patients.

The following example may illustrate a certain absurdity here: if an elderly patient for whom bedrails were not medically indicated climbed over the bedrails in an effort to reach the bathroom, tumbled, sustained an injury, or even died, a malpractice claim based on those facts alone would probably be unsuccessful. As things stand now in the United States, the hospital would have a strong defense based on industry custom. By using bedrails, the hospital would have demonstrated an effort to protect the patient; by climbing over the bedrails, the patient would have been unforeseeably "hostile or disobedient." Alternatively, the patient would be considered to have assumed the risk or been contributorily negligent. Therefore, the hospital would probably not be considered negligent.

The Response of the Nursing Profession

The nursing profession, usually held directly accountable for the safety of patients in hospital beds, has reacted. Rather than run the risk of malpractice accusations, nurses, perhaps prodded by hospital employers who are vicariously liable for their negligence, have generally advocated the routine use of bedrails for elderly patients. This decision can be seen in modern nursing manuals. For example, the Harvard University Health Services' general guidelines for nursing states in the section on safety factors: "The bedrails should be raised . . . when the patient is confused, disoriented, or restless; at night for most patients over 60 years of age and all patients 65 years and over."[23] *The Massachusetts General Hospital Manual of Nursing Procedures* in its "General Safety Factors" section states: "Bedsides should be raised . . . when the patient is confused, disoriented, or restless . . . [and] at night for most patients over 70 years of age."[24]

With the medical and risk management professions largely unaware of or denying the potential hazards of bedrails, with the legal profession anticipating malpractice suits, with insurance companies routinely settling claims in which bedrails were not up, and with the nursing profession and its employers fearing negligence liability, bedrails are now used for this country's hospitalized elderly in an indiscriminate fashion. The routine use of bedrails has become the standard of good nursing practice even though it has never been subjected to critical evaluation.

To an elderly patient who may be frightened or confused, how meaningful are a nurse's instructions to call for assistance before leaving the bed? Furthermore, there are circumstances when even the most clear-headed may not want to request help. For example, if a patient feels that nurses have more important tasks to do or if he calls for help to go to the bathroom and receives no immediate response, the patient may prefer the risk of falling while climbing over bedrails to the certain humiliation of not making the effort.

As far as could be ascertained, purposeful activity, rather than sedating medicine, time of day, or disorientation of the patient, seemed to be associated with falling out of bed.

We are not advocating the indiscriminate abandonment of bedrails. There are circumstances, not related to age, when bedrails are clearly indicated.

Table 2

Nature of Incident vs. Sedating Medicine*

	GOOB	NGOOB	NSF	
Sedating medicine	7	10	7	24 (45.3%)
No sedating medicine	9	8	12	29 (54.7%)
	16 (30.2%)	18 (34.0%)	19 (35.8%)	53 (100%)

(5 observations not recorded in the incident reports)
$X^2 = 1.33$ with 2 degrees of freedom (not statistically significant)

*Given within 6 hours of the incident. A sedating medicine was defined as one whose primary purpose was sedation or one in which sedation was a common side effect. These included hypnotics, analgesics, antihistamines, tranquilizers, and anti-emetics.

These include the delirious patient thrashing about in bed, the patient being transported on a gurney, the heavily sedated patient (pre- or post-operatively), the unconscious or intoxicated patient, and the patient who simply wants the bedrails in order to feel more secure.

Nor are we dismissing the aging process as a contributing factor in falls. Diminished ability to adjust to unfamiliar surroundings and increased likelihood of becoming disoriented, decreased visual and auditory acuity, increased sensitivity to medication, diminished physical performance, especially locomotion (particularly when chronic cardiac, cerebrovascular, malignant, or musculo-skeletal diseases add to the impairment) all contribute to falls because they contribute to the infirmity of elderly patients. However, infirmity alone is not necessarily an indication for bedrails. Although infirmity diminishes agility in ambulation, it does not diminish the desire or the ability to ambulate. Moreover, bedrails are not secure restraints and therefore cannot keep mobile elderly patients, however infirm, confined to bed against their will. Instead, bedrails may become a stumbling block and increase the risk of falling.

To alert the legal and medical professions to the necessity for making the distinction between a scientific standard and a "standard of consensus" is a principal goal of this article.

Bedrails in England

In England, bedrails ("cotsides") are not routinely used for the elderly. And yet England's hospital fall fracture rate of 0.7–1.7 percent is lower than the 1.5–3.6 percent rate of the United States, Canada, and other countries where bedrails are routinely used. One investigator found that GOOB incidents are practically nonexistent when the elderly remain in their homes, where bedrails presumably are not used. Although it may be argued that the elderly are usually well at home and sick in the hospital, one cannot dismiss the lower fracture rates in English hospitals. Nor can one dismiss our own findings and those of Ludlam that fewer slip-and-fall incidents were associated without bedrails than with them.

The difference in attitude toward bedrails between England and the United States undoubtedly reflects a difference in attitude toward the elderly. In the United States, the elderly tend to be infantilized and overprotected. In England, the elderly are encouraged to be independent. For example, in 1980, Morris and Isaacs reported on falls in an English geriatric hospital in which bedrails were routinely not used and independent activity was encouraged. They found that the risk of falling was low and concluded: "The prevention of all falls is not . . . an appropriate objective of patient management in departments of geriatric medicine. Instead, the aim should be the promotion of activity within acceptable limits of safety."

It was not always so in England. As recently as 1951, treatment of the elderly resembled the current approach in the United States. Thus, Amulree, Exton-Smith, and Crockett complained:

> Whatever the reasons for [the patient's] entry to hospital . . . he is put to bed and kept there, for the convenience of doctors and to maintain, for the sake of the nursing staff, the orderly appearance of the ward. . . . For the aged patient . . . such immobilization is often disastrous . . . Some hospitals have been prompted to withhold attempts at rehabilitation of patients who have a tendency to fall for fear of adverse criticism in the coroner's court. A tendency to falling is almost universal in aged patients, but can hardly justify such a nihilistic attitude. . . . It is always easier to keep patients in bed than to get them up. . . . Some believe, mostly out of sentiment, that people should be put to bed merely because they are old. . . . [D]irectly they are admitted to hospital, some patients who were ambulant at home lose their ability to get about. . . . Once in hospital, such patients are often waited on hand and foot.

Whatever the reason for the change in the English attitude toward treating the elderly since 1951, the change has apparently reduced the hazards associated with hospitalization.

Solving the Problem

When medical professionals in the United States and England have opposing beliefs on the value of routine bedrail use for the elderly, it becomes clear that a randomized, controlled study should be conducted to shed scientific light on the matter. The purpose of the "experiment" would be to evaluate whether a standard safety procedure actually protects the elderly or in fact creates additional hazards. Elderly patients for whom bedrails are not medically indicated (for example, sedated post-operative patients would be excluded from this study) would be randomized on hospitalization into three groups: one in which bedrails are used; one in which they are not; and a third in which half-length rails are used. The beds in each group should be the adjustable kind and usually kept at chair-seat height (low) so that patients may enter and emerge from them with ease. There would be no need to subject patients to high, standard hospital beds with their increased height from which patients might fall, since our study showed that falling incidents take place even when low beds are used.

There may be legal difficulties involved with performing such a study in the United States, today, however. Hospitals will naturally be concerned about their potential liability when bedrails are not routinely used for these elderly research subjects, but this article has shown that reasonable minds within the medical community already differ about the protective value of the alleged safety precaution. Thus, even though the current community standard of hospital care probably prescribes routine bedrail use for the elderly, that standard may harm the average patient more than it helps him. We hope that this article will succeed in its purpose of convincing everyone concerned that "standards" of care based on consensus rather than scientific evidence are meaningless, and that research must be done to establish what is in fact the best way to protect elderly hospital patients from falls.

Other legal, scientific, and ethical concerns might at first also appear to complicate doing such a study. We believe that the ensuing discussion presents reasonable ways to accommodate these concerns, however.

Ideally, the investigation should be "blind" to patients and their families to avoid bias in the results, but that raises obvious problems with respect to informed consent.[11] When the variable under examination is bedrails, informed and consenting patients can hardly be kept in the dark about the group to which they have been assigned for purposes of the study. The patient's knowledge that he is participating in a study designed to determine whether routine use of bedrails for the elderly is hazardous will alert him to the possibility of falling whether he is assigned to a group with or without bedrails. One could argue that this heightened awareness will be the same regardless of the group to which the patient is assigned—particularly when it is emphasized that falls occur in all groups—and therefore any bias would cancel itself out. The possibility exists, however, that all patients would exhibit extra caution in every group if they knew they were being studied, so that no falls at all would occur. In that case, nothing would be proven other than that when patients know their behavior is being observed, they tend to be more careful. While that in itself would be a valuable piece of information, it would be extremely difficult—if not impossible—to translate into a standard safety protocol for patient care.

On the other hand, if patients are not told that they are research subjects and therefore do not give informed consent, those who were in the group without bedrails and who fell might charge their health care providers with malpractice on the ground that they had not been informed that they would not be treated according to community medical standards. Moreover, if the investigation is federally funded or if the institution in which it takes place applies federal policy for protection of human research subjects to all studies performed on the premises, patient consent would be required unless the Institutional Review Board (IRB) can be persuaded that the study falls within one of the exceptions provided in the federal research regulations.[12]

The federal regulations applicable to human subjects research define research as a "systematic investigation designed to develop or contribute to generalizable knowledge."[13] The study we propose seems clearly intended to do just that, and thus informed consent would presumptively be required from participating patients if the study were federally funded. However, the hospital's IRB can waive the informed consent requirement if the research involves no more than minimal risk to subjects and cannot practicably be carried out in the absence of such a waiver.[14] Minimal risk is defined as being no greater in probability and magnitude than that "ordinarily encountered in daily life or during the performance of routine physical . . . tests."[15]

This article advocates that a randomized controlled study be conducted to determine whether bedrails constitute protection or a hazard to the average elderly patient.

We believe the proposed study would involve no more than minimal patient risk within the meaning of the regulations. In fact, the available evidence indicates that continuing the status quo may present more risk to the hospitalized elderly than conducting such an investigation. In any event, since neither using nor dispensing with bedrails for the elderly as a routine matter can be considered entirely safe on the basis of current information, there is no way to tell where the greater risk lies until such a study is performed. The regulations permit the IRB to approve a modified consent procedure when research risks are minimal, as well as to waive consent altogether. If the IRB were unwilling to approve the study without any patient consent, perhaps it would be sufficient to use a modified procedure wherein the patient would be requested to participate in a study evaluating routine nursing practices, without being given the details. The patient could of course refuse to become involved. If the study were not federally funded, each institution could obviously reach its own decision on the informed consent issue, within the limits of applicable local statutes.

The difficult question of whether informed consent should be required demonstrates the legal and ethical complexities involved with following Schimmel's sage advice:

> In the strategy of modern medical management, it becomes increasingly difficult to justify equivocal procedures with the comment "It can't hurt!" . . . The classical charge to the physician has been *primum non nocere*. . . . Physicians will best serve their patients by weighing each measure according to its goal and risks, but choosing only those that have been justified and by remaining prepared to alter the procedures when imminent or actual harm threatens to obliterate their goal.[16]

In this limited kind of situation where no medical evidence shows the superiority of one procedure over another, however, and where there are indications that the standard practice may in fact be hazardous, the reasons for securing patients' consent to participate in the investigation are less than compelling. This is not a case where the patient's right to individualized treatment is to be sacrificed in the name of scientific progress. The determination of whether there are clear-cut medical indications for providing the patient with bedrails will already have been made, and patients who clearly require bedrails for medical reasons will have been eliminated from the study. The purpose of the study would not be to determine whether a new, untested procedure has beneficial results, but to permit an informed judgment to be made about the risks involved with an untested practice, which nonetheless has already been established. In our opinion, the

Legal, ethical, and scientific concerns about informed consent may complicate performing this study.

study should not be considered experimental in the traditional sense, since no new procedure is being tested. We would argue that the patient's informed consent to participation may in these circumstances be legally and ethically unnecessary.

Pertinent to this discussion of the ethical issues of withholding informed consent in this kind of study is the recent article by Clements and Sider, entitled *Medical Ethics' Assault Upon Medical Values*. These ethicists argue that requiring informed consent when the "facts of the situation" have not yet been established constitutes an ethical assault upon the practice of good medicine. They wryly observe: "Since the content of [an ethical system] is only culturally or socially based, it reduces to subjective consensus. Moreover, those considered virtuous in a given culture, as Bertrand Russell observed, have done very bad things."[37]

We would like to believe that this paper will help to facilitate performance of the randomized, controlled experiment that needs to be done, and that lawyers would encourage such research. Both the medical and legal professions should distinguish between valid medical standards based upon scientific evidence and alleged medical "standards" based upon assumptions about what is in the best interests of patient care. The legal profession, no less than the medical profession, must be willing to discard a standard which is based upon an assumption, in favor of a standard based upon scientific evidence. The nation's elderly have the right to depend upon that for their own health and safety and for the enhanced quality of their remaining years. So do we all.

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RELEASING RESTRAINTS

a nursing dilemma

By Edna McHutchion, PhD, RN
and Janice M. Morse, PhD, RN

In recent years, there has been considerable discussion on the physiological and psychological consequences of using restraints, and the moral implications of restraining patients.[1,2] Despite these discussions, restraints continue to be used. Nurses report that although they dislike 'tying up' patients and feel guilty when they use restraints, they feel they have no alternatives. Nurses believe that the pressures of an excessive workload and the difficulty in maintaining patient surveillance, place the confused patient at risk of injury from falling or wandering from the unit. Patient safety however, is not ensured. Injury[3] or even death from strangulation, occur in restrained patient populations.[4-6]

The debate continues about the use of restraints as nurses wrestle with the dilemma of appropriate use of restraining devices.

It is paradoxical that the act of restraining patients jeopardizes patients' future mobility rather than increases patient safety. Kinsella[7] identified the irony of this practice by noting that nurses reason that if a patient is weak he/she may fall and break a hip, incapacitating the patient so he/she can't walk. Therefore, the patient is tied up, preventing immobility caused by a possible fracture.

Other reasons for restraining patients include the maintenance of treatment (such as wrist restraints to prevent the patient from removing tubes and lines), and the restriction of movement to protect other patients and staff from violence,[2] or to prevent patients from wandering.[8,9] Restraints are also used to maintain body alignment (e.g., to keep hemiplegics upright in a chair) or used because family members of the patient request that they be applied. Some authors have suggested that restraints are also applied to control patients who are resisting treatment or interfering with hospital routine by requiring extraordinary portions of nursing time.[10]

Mixed messages from society are also common. Some relatives share the hospital administrator's fear that their relative will fall and insist that their family member be restrained.

It is clear, therefore, that while restraints may be needed in extreme circumstances, it is peculiar that the use is so widespread. Several studies have shown that in North America 7% to 10% of the hospital population are restrained for approximately 50% of the time.[11-13] Moreover, certain patient populations, such as elderly, confused, and pediatric patients and formerly, obstetrical patients, are more likely to be restrained. In one study,[11] 20.3% of the patients over 70 years were restrained. Schilder[10] observes that once restraints have been applied, the use is perpetuated without question and individual nurses are often powerless to initiate the process of removal.

The purpose of this article is to explicate nursing dilemmas that occur when caring for the confused, elderly patient, and to suggest strategies for patient assessment for the removal of restraints. Further, examples will also be presented from experience obtained while implementing a research project that involves removing the restraints from two difficult patients.[15]

Nursing Dilemmas

The issue of restraining elderly patients is exceedingly complex and multifaceted. For purposes of this discussion, dilemmas will be classified as external (those arising from the hospital administrative, legal, and societal systems), and internal (those arising from the nurse's personal value system and from the constraints of the immediate work environment).

External

Administrators are ambivalent about the use of restraints. Uncertainty at the administrative level is evident to nurses who receive mixed messages. Nurses receive instructions to use restraints "only when absolutely necessary." However, nurses feel that if an incident occurred involving an unrestrained patient that the nurse providing care for that patient would be solely responsible.

In some institutions, nurses attempting to comply with administrative directives and maintain 'safe' practice, use substitutes as restraints to maintain patient control. Although not meeting the technical definition of a restraint, pajama pants or bed sheets are used as substitute Posey belts to restrain patients in wheelchairs. Some administrators do not consider locked geri-chairs or side-rails to be restraints, therefore, nurses are not required to follow procedures for caring for the restrained patient, such as exercising and periodically releasing the patient.

The legal system clearly places the responsibility for patient safety on the institution, the nurse and sometimes, the physician. Lawsuits for damages resulting from patient falls are relatively common and perceived by administrators to be a considerable liability risk.[16] Public hearings impair the reputation of the hospital and may be extremely costly. Incidents involving injury from the use of restraints occur less frequently than incidents occurring from the lack of restraints. Administrators therefore perceive themselves to be less vulnerable to suit through patient injury or death from the use of restraints.

Mixed messages from society are also common. Some relatives share the hospital administrator's fear that their relative will fall, and insist that their family member be restrained. In other instances, family members are abhorred to find that people actually are tied. Others are unaware of what is happening, viewing the restraint as a device to "help mother sit up straight in the chair" during visiting hours. Input to staff is even more perplexing when there is conflict within the family unit about the use of restraints. Theoretically, the use of restraints is a professional judgment, but the nurse feels pressured by family wishes and is aware of legal ramifications if an incident occurs and family wishes were not followed.

Unfortunately, societal attitude toward the treatment of the elderly is one of disinterest. It is ironic to note that some activist groups responsible for care of animals would not permit the use of restraints in zoos. The enforcement of human rights has been slow with the aged.

However, it must be noted that the authors found it relatively simple to judge and prescribe easy alternatives. Decisions regarding the use of restraints are difficult and outside observers with short-lived responsibilities for consequences may easily oversimplify a very complex problem.

Internal

Nurses empathize with the restrained patient, recognizing that they themselves would not wish to be in a similar position. At the same time, they feel the constraints of the work setting and the demands of other patients. Hospital wards have largely been constructed as small single rooms that will accommodate up to four patients. This design requires the nurse to leave the room frequently and makes patient surveillance from the nursing station impossible. Therefore, the nurse is unlikely to observe the patient making an unauthorized exit from the bed; thus the care of wandering patients is stressful and difficult.

Furthermore, the nurse is often behind curtains attending to the needs of other patients and cannot be constantly on hand to check the confused patient. Restraints have a distinct advantage of enabling the nurse to maintain control by keeping the patient in one place. Again, the nurse is acutely aware that she will be responsible if the patient falls or wanders into another patient's room or out of the institution. The futility of ensuring that these occurrences will not occur without the use of restraints, encourages the use of restraints.

> *Nurses empathize with the restrained patient, recognizing that they themselves would not wish to be in a similar position. At the same time, they feel the constraints of the work setting and the demands of other patients.*

Some nurses believe they gain enough time to get their tasks completed if certain problem patients are restrained. Understandably, the chaotic ward is anathema to nursing staff. If difficult patients are restrained, excellent custodial care may be provided on schedule. If patients are kept 'safely' in place, nurses can still complete all tasks in a shift, rather than experience prolonged delays which occur when attending to wandering, confused, and demanding patients. Conflicting external and internal messages add further complexity to the difficult work nurses do in providing safe and humane care for elderly patients.

Nursing Actions

Patient Assessment and Interventions

Given the considerations for and against restraints that have been described, the authors believe that nurses should not restrain patients unless it is absolutely necessary. In most situations a medical order is required. Psychological and physiological effects of restraints are known. Initially, the patient may be angry and hostile, but eventually becomes passive and regressed. Mental status is likely to deteriorate, and the patient may become incontinent. Schilder[10] documented that 22 (52%) of patients were alert on admission but when restrained, 8 (36%) remained oriented whereas 14 (64%) became confused. Furthermore, limitations of movement and impaired circulation of the restrained patient lead to deteriorated muscle function, joint stiffness and decubiti ulcers.

Thus, considering the initial reasons for restraining the patient, it is imperative that the need for restraints be constantly re-evaluated. Restraints should be removed at the earliest possible opportunity, before iatrogenic effects cause deterioration in the patient's condition. All patients with restraints should be re-evaluated at least once a shift to determine if the restraints are still required. For example, if the restraints were applied in an emergency situation because the patient was combative, it is possible that the circumstances which predisposed the combative behavior have been quickly corrected. Any continuing aggression may be caused by the restraints per se and could dissipate with the removal of the Posey belt. The evaluation should include assessment of the patient's gait, ability to weight-bear, and the patient's ability to realistically assess his or her own limitations.

Environmental Assessment and Interventions

For the ambulatory patient, orientation to place may be improved with the use of environmental cues, such as large signs by the patient's door and bed. Another consideration is to evaluate the noise levels of the unit. The continual sound of a radio or a television may add to the confusion of the patient with partial hearing loss, and inhibits conversation between patients.

Other environmental modifications will ease the process of nursing surveillance. Although bed alarms are not completely reliable and are sometimes difficult to hear, they provide assistance for some nurses with the task of monitoring patients at risk of falling. Alternative methods of surveillance are particularly important at night when there are fewer staff available and the ward is quiet. Door alarms triggered by inconspicuous tags placed on wandering patients are essential in places with severe winter climates, where wandering out of doors would be quickly fatal to debilitated, frail elderly patients.

It is essential that the patient's bed is low enough to permit the patient to climb out safely. Full length side-rails are exceedingly dangerous as the confused patient may be forced to climb over the top of the rails or to fall from the end of the bed. These rails should be replaced with three-quarter length side-rails which provide the patient with a safe path out of bed because the end-of-the-bed rail provides a convenient, supportive hand hold.

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Testing Removal of Restraint

A clear message of support from administration is essential if nurses are to take responsibility for removing restraints. It is suggested that the decision to remove patient restraints should be made at a meeting involving staff members from all shifts, including night nurses. If there is uncertainty about the patient's response, and if the nurses are concerned that they may not be able to manage the patient, a nurse to provide constant care should be available for 24 hours and the situation should then be re-evaluated.

In 1986, the authors conducted a study on the behavioral effects of removing restraints.[15] A psychogeriatric unit with 22 restrained patients was selected as the research site. An interesting phenomenon of this project was the staff response to the impending study. After reviewing the proposal, the staff met without the researchers and re-evaluated the reasons for restraining patients and discussed the effects of restraints on patient behavior. They subsequently removed the restraints from all but three patients without incident. Thus, at the commencement of the study, the researchers had to choose participants from the most difficult patients.

Observation data were collected by the use of continuously monitored video cameras situated in two sites for each patient: attached to the ceiling at the end of the patients' beds, (but situated so that if the curtains were pulled for personal care, the view of the camera would be obstructed) and in the day lounge. Any activities out of camera range (such as bathroom activities) were considered as "missing data." The project was conducted with ethical approval of the appropriate review committees, public guardians, relatives, nurses, and all auxiliary staff; ongoing consent was obtained from the patients. To further enhance patient safety after the removal of the restraints, bed alarms were placed in the beds. Ambularms were used when the patients were in chairs. Further, the cameras were continuously monitored, with intercom communication between the research assistant and the staff at the nursing station.

The first patient was an 83-year-old woman with a diagnosis of metastatic breast cancer. This patient had a colostomy and a past history of a fractured right hip. She also was occasionally confused. She had been restrained for 17 months, primarily because the nurses considered that her behavior was unpredictable. The patient described recurring, vivid dreams. She told researchers, for example, that men came in through the third floor window. The nurses charted that she was delusional.

On assessment the patient appeared oriented to time and place. She also reported that she was angry about being restrained. Because she was a fastidious person, she was distressed that the restraint prevented her from sitting close to her mealtime tray, and was embarrassed that food frequently spilled on her dress. On observation she appeared to move infrequently, but slept flat on her back or sat staring into space for long periods of time. She shared a four-bed ward, and sometimes attempted conversation with the other women, but frequently their chairs were too far apart to converse easily above the loud radio.

The researchers were surprised to note that nothing happened for a period of two weeks of continuous observation following the removal of restraints. There was no discernible change in her behavior; at no time did she attempt to move or stand unassisted. Her body position in bed when sleeping was also the same. At the end of the constant observational period, the researchers concluded that this patient had been restrained for so long that she was "psychologically restrained" and did not need to be tied for her safety.

The second patient, a 60-year-old woman considered to be mentally retarded had a medical diagnosis of epilepsy, neurofibromatosis, and probable organic brain syndrome. She had experienced multiple falls and had a past history of a fractured hip. She had been continuously restrained for 2½ years, and displayed considerable distress at being tied. She was frequently demanding, shouting unrelentingly for a bedpan, although medical examination for frequency of micturition revealed no pathological reason for the urgency. She displayed constant movement of her head and limbs, and her behavior was so frequently out of control that the nurses were afraid she would be a great safety risk if unrestrained.

Again, observations were recorded continuously for one week with restraints in use, and for two weeks following removal of the restraints. Despite the nurses' concerns, this patient was surprisingly aware of her limitations and did not take unnecessary risks. Only once, in the middle of the night, was the intercom used by the researcher to call nurses for safety purposes: the patient had moved to the end of her bed and appeared to be climbing out.

Analysis of nursing time and the number of nursing contacts showed that despite the increased number of nurse-patient interactions, nursing care time actually decreased. This indicated that nursing styles should change when the patient is unrestrained. The nurses no longer can work from one end of the ward to the other, changing and turning patients in sequence. Rather, patients' needs have to be met when the patient requests, and not primarily at the nurses' convenience.

The nurses no longer can work from one end of the ward to the other, changing and turning patients in sequence. Rather, patients' needs have to be met when the patient requests, and not primarily at the nurses' convenience.

Use of Alarm Systems

The Ambularm[6] and the Bed-Check[6] alarms proved to be relatively unreliable when used on these patients. Ambularm is a battery-operated alarm system attached to the at-risk patient by means of a garter placed above the patient's knee. When the patient stands or kneels, the Ambularm approaches a near-vertical position, a position-sensitive switch triggers an audio alarm. The Ambularm, when used in the current study with confused patients, was not satisfactory. It was manually removed by the patient and thrown across the floor, activated by hand, and used as a call bell to get the nurses' attention. Nurses also reported that it was difficult to hear from another room above the normal hospital sounds.

The Bed-Check alarm is an alarm system used to automatically monitor whether a patient is in bed, and alerts the staff if the patient begins to get up. The Bed-Check system consists of a control unit and a pressure sensitive strip which is placed beneath the bedsheet, under the patient's buttocks. However, for the purpose of the study, the Bed-Check with its four-second delay was considered to be too slow to alert the nurse in time to prevent the patient from falling, particularly when the patient was agile.

When the time lapse was reduced, false alarms were a common occurrence. Furthermore, it is important that these alarms activate the *emergency* call bell system rather than the *normal* call bell system. Nurses have to be able to differentiate between emergency and normal situations, such as the patient climbing out of bed, and the patient's request for a drink of water. Therefore, if the Bed-Check alarm is used, additional call bell jacks may have to be installed in order to activate the appropriate call bell system.

Conclusion

Although bed alarms may result in the prevention of some falls, these systems were not reliable because of human capabilities to circumvent the system. This project showed that difficult patients could be 'managed' without restraints. However, several factors must be considered.

First, the success of this project was probably due to relieving staff of at least some of the responsibility for surveillance. As one nurse remarked when it was proposed to remove patient restraints, "Fine, but not on my shift!" From judging the patients' behavior while restrained, it was predicted that an increased workload possibly would result. In response, the researchers provided an extra staff member at the busiest times of the day, thus alleviating the staff's concern that they may not be able to cope.

Over the short period of time that the researchers were on the unit, enthusiasm for the project increased remarkably. Staff's positive response led the authors to believe that given administrative support and obvious attention to the restraint dilemmas experienced by the staff nurse, many more patients formerly considered problematic or at risk of injury could be freed from debilitating and embarrassing restraints.

Current literature and examples from recent research experience were used to describe the dilemma nurses face as they work with nebulous restraint orders. External and internal forces exert stress on nurses as they attempt to provide safe patient care in busy long-term care units.

Nurses removed restraints from 19 of 22 restrained patients prior to the implementation of the researchers' study. This response to the proposed project suggests that increased awareness can result in a change in restraint practice.

However, the debate about the use of restraints continues as nurses wrestle with the dilemma of appropriate use of restraining devices. Although recognizing the complexity of the situation, the authors contend that nursing actions and environmental conditions must change if patients considered to be problematic or at risk for injury are to be freed from restraints.

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About the authors

Edna McHutchion *is Assistant Professor, Faculty of Nursing, University of Calgary, and a Clinical Associate at the Tom Baker Cancer Clinic in Calgary, Alberta.* **Janice M. Morse** *is Professor and National Health Scholar, Faculty of Nursing, University of Alberta, Edmonton, Alberta.*

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Restraints

KEY POINTS

McHutchion E, Morse JM: Releasing restraints: A nursing dilemma. *J Gerontol Nurs* 1989; 15(2):16-21.

1. Although there has been considerable discussion of the use of patient restraints in long-term care settings, the application and removal of restraints remain a major nursing dilemma.
2. External forces, such as hospital administration, legal, family and other societal pressures, and internal constraints such as the nurse's personal values and workload, continue to result in conflict for the staff nurse.
3. A report of a study on the behavioral effects of removing restraints is used as an example of exploring the experience and outcome of restraint removal and the ensuing staff experience of caregiving to the newly unrestrained patient.
4. Nursing actions and environmental conditions must change if patients considered to be problematic or at risk of injury are to be safely freed from restraints.

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Psychoactive Drug Misuse in Long-Term Care: Some Contributing Factors

David S. Sherman

Surveys have identified inappropriate psychoactive drug prescribing patterns as a major problem in the care of nursing home residents. Residents without a documented history of mental illness often receive drugs intended to treat psychiatric problems. One of the greatest areas of misuse of these drugs is in the treatment of agitation in elderly demented residents. For example, although this purpose is likely the most common reason antipsychotic drugs are used in the nursing home setting, no well designed study has yet demonstrated that these agents are effective for this problem. Elderly individuals are particularly sensitive to the adverse effects of psychoactive drugs. Due to the gradual or insidious onset of some adverse effects, psychoactive drug toxicity may often be underestimated. The most serious example of a clinically underrecognized adverse effect of psychoactive drugs is tardive dyskinesia. Misinterpretation of certain nursing home residents' behaviors may lead to medication with tranquilizing drugs when other approaches may be safer and more effective. Excessive use of psychoactive drugs is not only physically harmful, but also encourages an apathetic attitude toward implementation of more humane ways of dealing with behaviorally disturbed nursing home residents.

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EXCESSIVE PSYCHOACTIVE DRUG use in nursing homes (NHs) occurs due to a combination of complex social, psychological, economic, and medical reasons. An exploration of the origins of this problem is useful in the process of devising approaches to improve these utilization patterns.

While drug therapy may be a cost-effective approach for many physical and some psychiatric illnesses, behavioral disturbances in NHs are often not amenable to drug treatment. Medication, often the first line of attack, rarely solves the problem, and sometimes masks it.[1] Psychoactive drug intervention in demented behaviorally disturbed NH residents has not been shown to do anything more than sedate the patient.[2] In many cases, sedation will comprise what little mental function that may be left, thus exacerbating an already challenging management problem.

Various surveys have reported that 46% to 75% of NH residents have behavioral, social, emotional, and mental disorders, yet the recipients of psychoactive drugs often do not have psychiatric diagnoses.[3] The 1976 Office of Long-Term Care Survey of Physicians' Drug Prescribing Patterns in Skilled Nursing Facilities revealed that although only 10% of their sample had a clearly documented mental illness, nearly 50% of all residents were prescribed antipsychotic or sedative/hypnotic drugs.[4]

More recent surveys reveal these numbers have not changed significantly since the 1976 report. A review of 5,902 residents in Tennessee NHs found that 43% of these residents received antipsychotic drugs. The authors concluded that their findings provided "epidemiologic evidence suggesting misuse of antipsychotic drugs in nursing homes."[5] Further evidence of psychoactive drug misuse in NHs has been presented by experts in pharmacology during congressional hearings.[6,7]

REASONS WHY PSYCHOACTIVE DRUG MISUSE OCCURS IN LONG-TERM CARE

Desire to Help NH Residents

It is natural for NH staff to feel moved to relieve a resident's apparent suffering. Unfortunately, drug therapy that seems therapeutically appropriate for this purpose often yields an overmedicated elderly person.

Physicians are likely aware of the minimal benefit of psychoactive drug therapy for most behaviorally disturbed residents. Although these drugs are sometimes used to treat individuals with a history of documented psychiatric illness, more frequently they are employed as a pragmatic, symptom-based approach for the treatment of agitation in elderly demented residents.

From Health Care Visions, Inc and Division on Aging, Harvard Medical School, Westwood, MA.

Address reprint requests to David S. Sherman, BS Pharm, Health Care Visions, Inc, 57 Dover Rd, Westwood, MA 02090.

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No well-designed study has yet demonstrated antipsychotic drug efficacy for behavior problems of demented elderly NH residents.[8]

Belief in Psychoactive Drug Efficacy

No well-designed study has yet demonstrated antipsychotic drug efficacy for behavior problems of demented elderly NH residents.[8] However, healthcare professionals often prescribe, dispense, and administer these drugs, truly believing it is in the best interest of the resident. They are trained that intervention with drug therapy is the most logical approach for a resident with a problem behavior pattern.

Many behavioral disturbances are situational, and therefore, episodic in nature A drug is likely to be given credit for solving a behavior problem, when with time, it might just have likely resolved on its own. Staff are aware that a drug intervention is being employed and their expectation is that sedation is an effective and successful therapeutic approach.

Underestimation of Drug Toxicity

Some psychoactive drug side effects are gradual or insidious in onset. If a drug-induced problem is common in the population receiving the drug, association between the drug and the problem will be obscured. For example, a recent study identified sedative/hypnotics, particularly longer-acting benzodiazepines as the key cause of cognitive impairment in a sample of 300 elderly patients with suspected dementia.[9] This type of problem is difficult to detect because patients frequently are unable to report side effects, and those who care for them may not know how to differentiate adverse effects from underlying dementia or other changes resulting from advancing age.

Psychoactive drugs have also been strongly associated with the risk of falling.[10] This is a serious finding since falls are the leading cause of fatal and nonfatal injury in persons age 75 years and older.[11] One recent study found elderly recipients of psychoactive medications to be two to three times more likely to experience a fractured hip.[12]

The most serious example of a clinically underrecognized adverse effect of psychoactive drugs is tardive dyskinesia. Contrary to popular beliefs, tardive dyskinesia is not a rare phenomenon. The only antipsychotic drug adverse effect more common in the elderly is oversedation.[13] A recent study documented that despite its persistent nature, a diagnosis of tardive dyskinesia is often missed, especially when its symptoms involve the extremities rather than the "classic" orobuccal areas.[14]

The risks associated with psychoactive drug sedation of most demented patients far outweigh any perceived therapeutic benefit.

Behavioral Disturbance: Problem or Symptom?

An elderly NH resident may become agitated for a variety of reasons. Demented individuals frequently become agitated due to a misperception of environmental stimuli or due to unexpected actions of caregivers. An undiagnosed medical condition such as tumor, thyroid disease, acute myocardial infarction, or hypoxia could cause confusion and agitation.[13] Reversible dementias can occur as the result of infections, sleep deprivation, and a host of other conditions.[15] For a more complete review of this subject, the reader is referred to an excellent summary by Mahler, Cummings, and Bensen.[16]

The increased sensitivity of the elderly to a variety of drugs is well established. Elderly individuals are particularly susceptible to cognitive impairment as an adverse reaction to drug therapy.[9,17] This frequently results in confused or agitated behavior, and can occur even when drug therapy is prescribed and maintained at therapeutic levels.[18,19] Confusion or agitation in the elderly is often compounded with the addition of psychoactive drugs, which ironically have signifi-

Confusion or agitation in the elderly is often compounded with the addition of psychoactive drugs.

cant potential for causing behavioral disturbances themselves.[20]

Patient Demand

Some NH residents place great demands on the physician and NH staff not to discontinue current medication and even to add new drugs. As with many members of our drug-oriented society, these individuals are in the habit of taking drugs. Whether the habit reflects physical or psychological dependence, the prospect to the elderly person of having the drugs withdrawn may be a frightening one. In the process of rapidly eroding support systems that aging often represents, medication may unconsciously be considered a symbol of love by the often attention-starved NH resident. From this perspective, it is easy to understand why the resident might cling so tenaciously to each morsel of medication.

Environmental Control

Sometimes residents are sedated purposely because they create a disturbance that interferes with the controlled environment the staff and/or administrator may want to create. This type of treatment action usually does not involve any malice on the part of the staff, rather it is based on their mistaken belief that a tranquilized resident will be easier to care for. In fact, this misperception has been actively promoted by drug manufacturers in their advertising. Advertisements for antipsychotic drugs have offered the staff a "less complaining," "less demanding," "less dependent," more "cooperative patient" who is "easier to manage."[4] The message to the NH administrator is economic in nature and even less ambiguous: (1) "Relief of symptoms means a more amenable patient," and (2) "The less troublesome patient requires less nursing care."[4] These "scientific" reasons for using a specific medication play very nicely into the strong desire of many NH staffs and administrators for just this kind of assistance.

The irony in this fallacy is that on a practical level, a sedated resident requires more care. These residents are less able to perform activities of daily living, are harder to feed, harder to get out of bed, more likely to be incontinent, and more likely to injure themselves. All of these aspects of care require more nursing time and result in increased incontinence-related material costs.

Another management concern in the NH is the runaway resident, especially one who is confused or mentally disturbed. Possible accidents or injury and attendant personal liability and bad press are constant sources of apprehension and stress for the NH administrator.[21] Often psychoactive drugs are used to manage this problem instead of door alarms and other surveillance methods.

Consultant pharmacists are often approached by staff/administration requesting information on "what drug can we get the doctor to order to shut 'that one' up?" As the author of one study stated, "Indeed, it can be argued that in the absence of psychoses, the use of neuroleptics for elderly patients-residents serves institutional rather than individual needs."[22]

Family Concerns

Family members may request that "annoying" roommates be tranquilized because they are disturbing Mom or Dad. Conversely, family members may request that Mom or Dad by tranquilized because they appear uncomfortable and they "can't bear to see them that way."

Most people, particularly older people, have a deep aversion to NHs. A family member may often feel that they have abandoned their loved ones by opting for NH care.[23] This guilt can sometimes result in requests for "comfort measures" (ie, tranquilizers) that might not be in the resident's best interest.

Nursing Staff Stress

The NH can be a stressful workplace, and some staff members are better able to tolerate this than others. The more stress an individual feels, the less disturbance they are able to tolerate in their environment. Caring for demented elderly residents can be very challenging. To many nursing staff members, it may be easier to get drugs prescribed that will keep residents quiet than actually deal with the behaviorally disturbed individual on a personal level.

Contrary to negative media portrayals, most NH staff members work hard to provide the best care possible. Given the opportunity, they are interested in learning new approaches that might help them provide a higher quality of care. Staff trained to become attuned to the specific rhythms of each demented individual are more likely to consider options other than drug therapy. By identifying the cause of the resident's disturbed behavior, a nondrug solution often becomes readily apparent.

Inadequate Training

Several studies have reported that current resources of NHs appear to be inadequate to respond to the emotional and behavioral needs of their residents.[3] There is a lack of systematic approach to the care of persons with behavioral, social, and emotional problems, as well as the mentally ill.

One of the biggest obstacles of decreasing inappropriate psychoactive drug use in NHs is the dependence of physicians, nurses, and nursing assistants on the drug approach as the only one with which they are familiar. Since physicians are not trained in the skills of situational-behavioral problem solving, they may lack an organized approach with which to respond efficiently and effectively to the problem.[24] Although nurses and nursing assistants generally are able to acquire these skills experientially, they often feel unable or disinclined to implement them consistently due to the pressures inherent in their normal work day.

Influence of Drug Manufacturers

The busy physician tends to rely heavily on drug company literature, advertising, and "detail men" (sales representatives) for his information. This is unfortunate since drug manufacturers are in business to sell drugs, not to educate doctors. Information from pharmaceutical and manufacturers (via advertisements, direct mail, exhibits at conferences, and visits by sales representatives) is crisp, attractive and accessible, but understandably, it is oriented toward promoting a particular product. Consequently, the information drug companies publish and distribute is often calculated to emphasize the likely benefits of the drug and to minimize the potential dangers.

> ***. . . drug manufacturers are in business to sell drugs, not to educate doctors.***

Over $3 billion per year is spent on promotion by US pharmaceutical companies. About 15% of this is spent on journal advertising. Since nearly all physicians read medical journals, drug manufacturer advertisements and the images and information they contain are almost impossible to avoid.

Drug manufacturer advertising attempts to invoke powerful feelings in prescribers: compassion, guilt, fear, anger, control, and success to name a few. All of these feelings play a part in influencing the prescriber's future therapeutic decisions. The people who prepare these ads are very clever, and their intent is not to intellectually convince, but rather to plant a seed in the unconscious, ready for future harvesting.

One study of a group of randomly selected primary care physicians found drug manufacturer advertising encouraged inappropriate drug therapy. In this survey, drugs were chosen for which commercial messages on product efficacy differed markedly from objective, scientific sources of information. When the physicians were asked how effective these drugs were, their answers corresponded most closely to the commercial information.[25]

Sales activities of pharmaceutical representatives account for over half of the $3 billion per year spent by US pharmaceutical companies. Since the content of "detailers' " sales messages cannot be monitored as can the content of most other forms of advertising, this marketing approach represents an almost totally unregulated activity.

The proof of the effectiveness of this approach is the financial investment of pharmaceutical companies to continue this activity. If product sales in excess of detailing costs did not occur, other marketing avenues would take precedence.

EDUCATIONAL EFFORTS TO IMPROVE PRESCRIBING BEHAVIOR

All the factors mentioned earlier may contribute to inappropriate psychoactive drug use patterns, but the main reason this problem continues is due to the attitudes and beliefs of misinformed prescribers and NH staff. Logically, the best way to deal with misinformed individuals is through education. However, previous work has documented the failure of traditional methods of continuing medical education in influencing the quality of patient care.[26] Studies have also shown that provision of printed educational materials alone is not successful in influencing physician prescribing behavior.[27-28]

New regulations from the Health Care Administration specifically address this problem of psychoactive drug misuse.[29] These regulations encourage the use of nondrug approaches and require that caregivers in NHs document the effectiveness of currently prescribed antipsychotic drugs. It is clear that a new approach to this problem is needed.

In view of the impact that marketing and promotional activities of drug manufacturers can have on prescribing behavior, it made sense to explore how an educator might use this approach to influence physicians in a noncommercially oriented fashion.[30] "Noncommercial detailing" is a face-to-face educational method that draws from and expands on marketing techniques that have been used by drug manufacturers for years. These techniques can be adapted to encourage appropriate and cost-conscious prescribing instead of promoting the vested interests of a particular pharmaceutical company. With this approach, clinical pharmacists can effectively expand their influence on physician prescribing behavior in a prospective manner.

Noncommercial detailing has been used to successfully influence prescribing behavior in office-based physician practices.[27-28] In an ongoing project the author (DS Sherman) has trained clinical pharmacists in this approach in an effort to reduce pharmacy costs in a four-hospital Veterans Administration study. In a recently completed Harvard Medical School study the author adapted this noncommercial detailing approach to influence prescribing of psychoactive drugs for NH residents. In addition to 1:1 sessions with physicians, a series of presentations describing specific nondrug behavioral techniques as alternatives to psychoactive drug therapy were provided for NH staff. Preliminary analysis reveals that unnecessary psychoactive drug use has been reduced significantly in 12 target NHs.

SUMMARY

Excessive psychoactive drug use is unhealthy for NH residents, an indirect expense and a public relations problem for NH administrators, and a source of frustration for consultant pharmacists concerned with encouraging appropriate drug use. Overmedicated NH residents experience a lower quality of life and are harder to care for. Misuse of psychoactive drug therapy is not only potentially dangerous for each individual patient, but it fosters an apathetic attitude towards implementation of more humanistic ways of dealing with the behavior problems of elderly NH residents.

This paper identifies factors contributing to the problem of psychoactive drug misuse in elderly NH residents. The identified factors are not intended to be a summary statement, but rather a stimulus for further discussion of this challenging problem in the health care community. Noncommercial detailing is an example of an innovative and effective educational approach for reducing inappropriate drug use. The consistent success of this approach in influencing physician prescribing behavior has made it clear that a wider application of these techniques would be useful to the health care community at large.

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LIBERATION: ALTERNATIVE TO PHYSICAL RESTRAINTS

The use of physical restraints in United States nursing homes is deservedly evoking attention and concern. The increasing numbers of women and men to whom restraints have been applied, usually the most frail residents of our nursing homes, have all along been rejecting these devices in every possible way they could express themselves. Depending upon their differing personalities and functional states, they have objected verbally, sometimes with heartbreaking sadness, sometimes with hostility, and with body language, either the dropped head and hunched shoulder of withdrawal and depression or outright physical resistance. Some in desperation beseech every passer-by to release them.

Many caregivers, too, at all levels of training, have had misgivings about our practice of tying people down. In this decade the increasing concern of researchers to determine in full dimension the effects of physical restraint is indeed welcome. The paper by Folmar and Wilson in this issue examines one aspect of the impact of physical restraints — the effect of restraints on social behavior.

The nationwide prevalence of restraint use has increased in the last twelve years from about 25% to 41% of all people living in our nursing homes (DHEW, 1979; HCFA, 1988). As Evans and Strumpf's review of the literature reveals (1989), the reported destructive effects of physical restraints include loss of bone mass and muscle function, changes in metabolism, increase in incontinence, depressed psychological states, and injuries incurred in attempts to remove the restraining devices. Recorded deaths (Fried, 1987) caused by restraint use number at least 35 in the U.S. and Canada between 1980 and 1987. Two more people are known to have burned to death as the result of trying to free themselves by setting fire to their restraints. However, these numbers are underestimates because of under reporting, inaccurate documentation, and lack of centralized reporting requirements. Stress on staff involved in the use of physical restraints is indicated by the doubts and internal conflict reported in a study of patient and nurse perceptions of the experience (Strumpf & Evans, 1988).

To discover that in other countries, among them Scotland, The Netherlands, Sweden, and Denmark, care of chronically sick older people is virtually restraint free, is to experience a sense of liberation from the spot in which we in this country have been wedged, between the torture (not too strong a word) of the restrained and the restrainers on one hand, and, on the other, the belief that there were no alternatives (Williams, in press). The key to restraint free care, I learned from Ulla Turemark, Administrator and Director of Nursing, Gròbergets Nursing Home in Göteborg, Sweden, is to practice "individualized care," centered on the person, and his or her particular needs. Individualized care looks at and aims to respond to the person's life experiences and customary daily routine, including the preferred small daily activities, as well as the need for an environment that speaks to the person as a social being. It grows out of full respect for the sick older person as an adult with fundamental rights, including the right to freedom of body movement and the right to choose to take risks as all adults commonly do.

As a result, individualized care develops capacity for flexibility of schedule, for putting personal individual needs in a place of priority, rather than maintaining inviolate schedules and accomplishing certain tasks which are determined by staff. Flexibility then permits choice by the individual resident in such important aspects of daily living as hours of arising and retiring. To enhance both comfort and appropriate care, the expertise of the occupational therapist is extensively used. Rather than applying a restraint dubbed "postural support" or "protective safety device," ease and desired body alignment are achieved through thoughtful selection of chairs and liberal use of positioning pillows and pads.

Particular effort is put into understanding the needs of the person with dementing illness, with extra time in the first several weeks purposely spent in learning to know the resident well and learning sources of discomfort *and* comfort for her or him. As a result, a visitor to Gròbergets Nursing Home, which has a patient population similar to our skilled nursing facilities, hears far less crying out and sees fewer signs of agitation among people living there than one commonly sees in U.S. homes.'

All staff — nurse, administrator, physician, social worker, occupational and physical therapists, cook and housekeeper — are included in a continuous education program in an effort to advance constant

Carter Catlett Williams, MSW
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learning and promote the on-going process of discovering new ways of individualizing care. This kind of care leads to increased satisfaction on the part of caregiving staff and it generally demands a different kind of training rather than an increase in numbers (Goldman, 1989).

In this country, too, we have practitioners of vision who have practiced restraint free care for many years, notably Kendal-Crosslands, a life care community at Kennett Square, PA (Blakeslee, 1988). Now, increasingly, other nursing homes across the country are learning and demonstrating restraint free care.

Work by many researchers supports the urgent need of developing individualized care practices in this country. From the research of Rodin and Langer (1976) we have known for years of the importance of choice, responsibility and control to the well being of people living in nursing homes. Feil (1982) has pioneered techniques of responding to the feelings and emotions of people with dementia, and we know of the benefits of this approach, further conceptualized and developed in nursing practice, in the work of Rader, Doan and Schwab (1985). From Rosalie Kane (Kolata, 1989) we have reliable knowledge of the aspects of daily life over which residents most desire control. Atchley (1989) puts forward the salient need of the older person to experience continuity. For the person living in a nursing home a sense of continuity has to rest in large measure on the ability to control the small details of daily life.

It is not enough to speak only of removing restraints, both physical and chemical (for the latter must not be allowed to proliferate even further to become a substitute for the former). We must conceptualize, develop, and test our own ways of individualized care and work out new standards of care based on the well-being of the whole person. The legal noose now thought to be around the necks of the nurse, physician, and nursing home administrator who do not restrain every resident who falls or may fall, must be exposed for the myth it is (Hunt, 1986; Mitchell-Pederson et al., 1985). Furthermore, caregivers must absorb the significance of the mounting evidence that as many falls occur in restrained people as the unrestrained (Goldman, 1989), and that serious injury falls do not increase significantly in the absence of restraints (Mitchell-Pederson, 1985).

We must learn how to restore to all people — friends, relatives, clients, our future selves — those elemental human rights for choice, a sense of control, for respect and dignity that are as necessary to daily life in a nursing home as in any setting. We must reach families and friends of nursing home residents, current caregivers and those who educate health professionals in all disciplines at all levels with the concepts and practices of individualized care. It is heartening that the nursing home reform legislation in the Omnibus Reconciliation Act of 1987 calls for careful assessment of each resident's function and its language repeatedly implies attention to the resident as an individual. It is imperative too, that these concepts permeate our federal and state survey systems, which until recently have been geared not to resident outcomes but to paper compliance with the regulations. The voice of the person who lives in the nursing home must finally be heard and attended.[1]

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[1] The discussion of individualized care is based on consultations with U. Turemark, Gröbergets Sjukhem, Stortoppsgatan, 41457, Göteborg, Sweden on May 25 and May 27, 1987.

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Carter Catlett Williams, MSW
Social Work Consultant in Aging
Bethesda, MD

UNTIE THE ELDERLY
PHILOSOPHY AND PURPOSE

Dignity, independence, and a sense of control become more precious to the older adult as emerging limitations and personal losses become a common way of life. Living in an ageist society, older people are often devalued and subject to dehumanizing treatment, especially in the area of health care. The use of physical restraints in long term care is the epitome of such treatment. A physical restraint is any device used to inhibit a person's free physical movement. In American nursing homes, their use is common practice in the care of elderly who wander, appear physically abusive, or are so frail that they are considered likely to fall. Many staff in facilities believe that the use of physical restraints is the most effective way to protect their residents from injury or from harming others.

Kendal at Longwood and Crosslands, two not-for-profit continuing care retirement communities, are in direct opposition to this belief. Their philosophy honors an older person's basic human rights to be treated with respect as an individual and to be protected from neglect, discrimination or physical and psychological abuse. Stemming from this philosophy, the communities have had a policy of restraint free care since their inception. Over the past fifteen years, the policy has proven that safe, quality care can be delivered without using physical restraints. Studies show that the two communities have no more injuries from falls than facilities that do use restraints.

Researchers have documented that restraining older people does result in chronic constipation, incontinence, pressure sores, loss of bone mass, muscle atrophy, decreased ability to walk, and eventual invalidism. Combined with the loss of dignity, withdrawal, and other emotional problems, it is a tremendous price to pay to prevent a possible injury. While the use of physical restraints is believed to be for the resident's protection, the physical, emotional, and spiritual well-being needed for rehabilitation is destroyed.

The Kendal Corporation takes an active role in shaping public policies affecting the aging, supporting legislation and regulation for consumer protection, and fighting against ageism and the infringement of basic human rights. Guided by the mission to be a leader in care for the aging and an activist regarding aging issues in our society, The Kendal Corporation has championed restraint free care and developed a program for eliminating physical restraints in long term care facilities. In an effort to preserve the autonomy and dignity of the older adult and provide quality life and health care, UNTIE THE ELDERLY is an initiative to:

- increase awareness of the damaging effects of physical restraints;
- offer the support and expertise to facilities interested in implementing a no-restraints policy;
- influence legislators and public policy, thus impact the quality of care in nursing facilities on a national level.

Untie the Elderly - Philosophy and Purpose

Qualified staff offer experience and expertise to:

- increase awareness regarding residents' rights, legal implications and negative aspects of physical restraints;
- provide specific, step by step information on how to eliminate the use of physical restraints;
- generate and implement alternatives in long term care facilities;
- introduce policy changes to Boards, physicians, staff, residents and their families;
- develop policy/protocols for restraint-free care;
- provide current research findings and case studies regarding restraint-free care;
- facilitate creative problem solving for difficult cases;
- support lobbying efforts to change legislation.

Kendal identifies the elimination of physical restraints as the single most important factor that can improve the quality of care delivered in nursing facilities across the nation. The dehumanizing effect restraints have on both the caregiver and the resident has a profound impact on the total caring process. Staff become complacent about using them, believe that they are necessary to manage patients and consequently use them as a means of control. A physical restraint is in direct conflict with the concept of autonomy, and its use undermines the ability of the caregiver to perceive and interact with the older person as an individual.

In the words of the late Emily Wilson, a physician and resident of Kendal at Longwood, a restraint is "an insult to, an attack upon, the unique spirit of a human being; it treats him as less than human, it manipulates him, it destroys his self-respect. It is imposed upon confused, inarticulate, difficult people who are given no choice in the matter."

Dawn Papougenis, Project Coordinator
UNTIE THE ELDERLY
The Kendal Corporation
P.O. Box 100
Kennett Square, PA 19348
(215) 388-7001, ext. 268

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Kendal —
Crosslands

BOX 100, KENNETT SQUARE, PA 19348 TELEPHONE (215) 388-7001

USE OF RESTRAINTS

Kendal at Longwood believes that any form of restraint is an assault on the dignity and the physical and emotional well being of the older person. We expect our care-givers to use more humane ways of meeting the needs of our residents.

Restraints are not used in this facility except in the case of severe emergency. Should a resident become extremely aggressive, destructive or otherwise violent, restraint may be necessary until appropriate treatment can be initiated.

Locked restraints and geri-chairs shall not be used at any time.

Restraints shall not be applied in such a manner as to cause injury to the resident.

A. The Charge Nurse will make the immediate judgment as to the emergency procedure necessary to protect the resident from injury to him/herself or those around him/her. If physical restraints are necessary, a staff member must remain with the resident while the restraint is in use.

B. The physician must be contacted immediately. The continued use of restraints and/other appropriate treatment will be ordered by the physician.

C. Orders for physical restraints shall be renewed by the physician every 12 hours. There shall be a signed, dated, written physician's order for physical restraint. This includes the use of the posey, chest, waist, wrist, ankle, or other form of restraint. The physician must visit and evaluate the restrained resident at least once every 24 hours while restraints are used. The physician must document, in detail, the reason for the restraint order each time the resident is evaluated.

D. A member of the health services staff must remain with the resident until the physician states restraint is no longer necessary, and must carefully document the entire incident, hour by hour, in the medical record.

E. It may be necessary to transfer a disturbed resident to another facility for appropriate treatment. The attending physician will make this decision and will make the arrangements with assistance from the staff.

Kendal™ at Longwood and Crosslands are not for profit communities for older people governed by a board composed of members of the Religious Society of Friends (Quakers). Both Kendal™ at Longwood and Crosslands are accredited by the Continuing Care Accreditation Commission of the American Association of Homes for the Aging.

IMPLEMENTING A NON-RESTRAINT PHILOSOPHY

BY RUTH ANN ENGLISH, RN, BSN, MEd

Nurses at the Vancouver General Hospital are caring for their elderly patients with unrestrained pride.

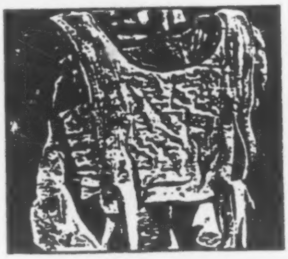
As nurses, we use restraints with the best of intentions to protect our patients. Unfortunately, these devices have occasionally caused serious injury or even death to the people we are trying to protect. And all nurses have heard patients' heart-wrenching accounts of how it feels to be restrained: "I felt like a dog and cried all night. It hurt me to have to be tied up. I felt like I was nobody; I was dirt. It makes me cry to talk about it. The hospital is worse than a jail."[1] Two years ago, nurses at the Vancouver General Hospital (VGH) decided we had had enough; it was time to change our philosophy and practice of the use of restraints.

Numerous articles in nursing and medical literature of the past few years describe the overuse and abuse of physical restraints on elderly patients. Nursing staff restrain 10 percent or more of patients admitted to non-psychiatric wards of general hospitals in Canada.[2] Patients 70 years of age or older are eight times more likely than younger patients to be restrained.[3] Nurse administrators and nursing staff are admonished for using restraints as part of ward routine, without proper assessment and documentation, and often to compensate for staff shortages.[4]

Particularly troubling are the possible physical problems caused by immobility—aspiration, bone resorption, skin breakdown, urinary retention and fecal impaction—and the emotional destructiveness of fear of abandonment and loss of self-esteem.[5] Nurses and physicians feel caught in the dichotomy of protecting the patient and preserving patient autonomy. But it seems we are guided more often by the principle of safety first than by freedom first, especially in our care of elderly patients.

At Vancouver General Hospital, no longer feeling comfortable with the way we were caring for our elderly patients, we decided to take up the challenge of changing our philosophy of restraint to one of non-restraint. Now, about two years into the project, we are sensing a widespread movement toward non-restraint within the Canadian nursing community. Our experiences and strategies may help others trying to implement a non-restraint philosophy.

Whether in a large hospital or a small facility, implementing the non-restraint philosophy can seem overwhelming; restraints are an emotional issue, and the change process required is complex. Using a three-stage approach—development of a core group, trial project and facility-wide implementation—plus reviewing the literature on planned change, makes the project manageable.



The three components of the task might be represented as widening circles of change. A small circle is formed by a core group; the circle is widened when the philosophy is tried on one or two units; the final circle is facility-wide, fully implementing the non-restraint philosophy.

The core group

The process is started on a small scale with the formation of a core group. At our hospital it started with the nurse manager of our geriatric assessment and treatment center, myself, a head nurse, an assistant head nurse and two instructors. The manager and one instructor were the people with a knowledge base of geriatric nursing. It was their task to convince the acute-care members of the group that a better way of caring for elderly patients existed, without using restraints.

Core groups must include one or two members who have geriatric nursing knowledge, experience and commitment. At least one member must have enough administrative power within the institution to enact or facilitate policy change. A head nurse is a critical prospective member, as a key person to implement change at the unit level and to influence other head nurses within the institution. A nursing instructor is valuable in planning the education that must accompany the change.

It is particularly important that one or two members of the core group have the motivation, commitment and drive to stick with the project over the long term. Some members of our core group have changed, but two have remained constant, moving the project forward through the remaining phases.

The core group must become conversant with the literature on restraint and non-restraint of patients. It is critical for the group to discuss fully the issues surrounding restraint and non-

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Ruth Ann English is director of geriatric nursing, Vancouver General Hospital, Vancouver, British Columbia.

restraint, argue both sides of the policy and feel convinced that a philosophy of non-restraint is the goal to achieve. The core group's task is to teach other nurses and administrators about the alternative ways of caring for patients without using restraints; hence, the group's conviction and ability to answer numerous concerns and questions is vital to the success of the project.

One member of our core group experimented on her nursing unit with the concept of non-restraint. Having assessed two patients carefully, she removed their restraints. Within the group, she enthusiastically described the progress of the patients as they became more mobile and independent.

Trial project

Our opportunity to begin the second stage came when a social worker assigned to one of our two long term care units expressed concern about the number of restraints used on these patients. Collaborating with the core group, the head nurses of the long term care units agreed to a trial project to implement a non-restraint philosophy. The project necessitated a policy and procedure outline of our expectations for the use of restraints, incorporating the philosophy of non-restraint as much as possible.

A task group was formed to develop the policy and procedure. Two members of the core group, the two head nurses, the social worker, a clinical nurse specialist (geriatrics) and an instructor worked together to develop a policy, procedure and consent form.

The task group repeated the process of the core group, reviewing literature and arguing the case for non-restraint of the elderly patients on the units. The two head nurses feared an increase in the number of falls on the units and, therefore, an increase in injuries. The former happened; the latter did not. Once the head nurses were assured of administrative support from their director of nursing and clinical support from the clinical nurse specialist and instructor, the task group moved on to the development of the policy and procedure.

The policy stated that patients on the long term care units would be free of physical and chemical restraint; if absolutely necessary, the least restraint possible would be used. We identified what circumstances might demand, as a last resort, the use of restraints. If restraints were used, meaningful explanations must be given to patient and family. The policy indicated that staff must be aware of the consequences to patients when restraints were used, and described possible alternatives to restraints.

We also developed a consent form to be completed by social workers throughout the hospital before restrained patients were admitted to the long term care units. The consent was to fulfil two objectives. First, the form let families and patients know that, although the patient was restrained on the acute care unit, the transfer was to a unit with a philosophy of non-restraint; by signing the consent they indicated they understood what the transfer meant and were in agreement. Secondly, we wished to alert the nurses in acute care about the change in practice taking place in another part of the hospital. I hoped the form would cause cognitive dissonance within nurses in acute care: "If the long term care nurses can care for this patient without restraints, why can't we?"

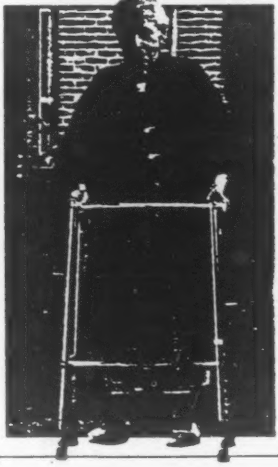
The procedure we developed outlined what the social workers would do with the consent form and what the nurses must do if restraints were used. If restraints were indicated after a thorough, careful assessment, the nurse had to follow specific steps in documentation, safety checks, position changes and ongoing reassessment of restraint use.

Once the policy, procedure and consent were completed, members of the task group, which included the director of nursing for long term care, met with nurses from the two units. Having the director of nursing or a senior nurse administrator present is essential in order to indicate administrative support for the philosophy, policy and procedure.

A primary objective of the meeting was to elicit and deal with the nurses' concerns and fears about the implementation of a non-restraint philosophy. Nurses often fear legal reprisals should an unrestrained patient fall and fracture a bone. The nurses should be made aware that "while there is no recorded incident of litigation in Canada because restraints were *not* used, there is record of litigation because they were."

It is helpful to discuss patients currently restrained and to explore alternative measures. The nurses at our meeting provided several creative alternatives to restraint, once given "permission" and encouragement.

Likewise, two members of the task group met with the hospital's social workers to outline the trial project and the part we were asking them to play. The social workers were provided with



Heather Dixon

reading material and the policy, procedure and consent form. Having the support of these people was essential, as they would be interpreting our policy to potential patients, families and staff members on the acute care units.

The trial on the long term care units progressed well, with the head nurses providing the on-site leadership and motivation. Within ten months of implementation of the new philosophy, interesting changes in nursing practice were going hand in hand with the non-restraint philosophy. Not only were most patients unrestrained, they wore street clothes and were encouraged to mobilize and to increase their independence. But the best news was yet to come.

Unaware of the impact the change of practice was having on the units from a broader perspective, we were surprised to receive a memo from the president of the hospital asking us what was happening on the long term care units. While reviewing hospital statistics, he noted a 49-percent decrease in the average length of stay on the two units over the previous ten months. It was a pleasure to write back to him describing our trial project; we believed the decrease in length of stay was related to the improved mobility level of the patients. All patients on the long term care units were awaiting placement in other facilities; experience shows that the more mobile the patient, the shorter the wait for preferred accommodation. The longest waiting lists are for facilities in which residents are severely disabled and require extensive nursing care.

An unanticipated but valuable effect of the non-restraint project was the increase in staff morale. Staff on the long term care units are justly proud of the way they nurse the elderly patients entrusted to their care.

Reaching further

With the success of our trial project behind us, we were ready to expand the project facility-wide. Our opportunity came when the nursing executive decided to revise and update our nursing division policy and procedure manual. I volunteered to prepare the policy and procedure for patient restraints. This document outlined when restraints might be used on patients and detailed the use of each type of restraint.

The elderly are far more likely than young patients to be restrained inappropriately

I was joined in the task by a student from the administrative stream of the University of British Columbia's Master of Science (Nursing) (MSN) program. A requirement of her program was that she complete a project while working at our hospital. Chairing a committee to develop a draft policy and procedure entitled "Restraint/Non-Restraint of Patients" was to be her project.

The committee included another member of the core group and one of the head nurses of the long term care units. This nurse, a strong advocate of the non-restraint philosophy, could influence other head nurses in the hospital. Since our hospital is large and has five clinical nursing departments, we decided we needed one head nurse volunteer from each department. That person would be the liaison between the committee and the head nurse/director groups. We also included a representative from the social service and physical medicine departments of the hospital to obtain their input and keep their departments updated on the project.

Before the first meeting we sent reading materials to the committee members, including the current policy and procedure for patient restraints, the non-restraint policy and procedure of the long term care units and a recent article supporting non-restraint of elderly patients. We emphasized elderly patients because the elderly are far more likely than young patients to be restrained inappropriately.

At our first committee meeting, we once again worked through the initial reservations about the concept of non-restraint of the elderly patient. Two one-hour meetings were spent discussing and arguing the rationale for a non-restraint approach. The head nurse volunteers tended to fall into one of two categories: opposed to non-restraint; or skeptical but interested.

In retrospect, it was critical that a head nurse from the long term care unit was present who was a strong proponent of non-restraint, had survived the implementation on her unit and was positive about the results. She was able to allay each of the head nurses' fears.

Once convinced we were headed in the right direction, the committee began writing the policy and procedure. Each draft was taken to the respective head nurse groups for input and comment. The completion of a draft copy of a policy and procedure approved by the whole committee coincided with the MSN student's departure ... assignment completed.

Our committee still had to implement a philosophy, policy and procedure significantly different from current practice. How could we accomplish this goal in such a large facility?

We identified four tasks to be completed in implementing our new approach: contact influential people who could assist implementation; identify a method of communicating our philosophy of non-restraint; survey current use of restraints in the hospital; and plan implementation of "Restraint/Non-Restraint of Patients" policy and procedure.

Contacting influential people: We decided that each group of influential people needed the opportunity to have input into the draft policy and procedure and to ask questions or express concerns about the new approach. We identified influential people as persons within the hospital system who had an impact on the planning and implementation of patient care. (We were not yet targeting bedside nurses.) The people identified were the five head nurse groups, senior physiotherapists, senior occupational therapists, instructors from the staff development department and instructors from the school of nursing. The social worker group was eliminated, because we had already met with them and believed they supported us.

Two members of the original core

group and the head nurse of long term care met with each of the influential groups. By the last of the meetings we had the sense that, for the most part, people were comfortable with the philosophy of non-restraint and were ready to proceed.

Communicating the philosophy: Communicating our philosophy to hundreds of bedside nurses would be difficult. On completion of our final draft policy and procedure we were left with a document having only one statement on non-restraint, while the rest described the circumstances under which restraints might be used and the procedures for use.

We decided a video production would be the best format to communicate our message of non-restraint. Having surveyed the market, previewed all available productions and found none suitable, we approached the vice-president of nursing for the substantial funding required for our own video production. Six months later, a VGH Nursing Division and University of British Columbia Bio-Medical Communications Department co-production was completed: *Restraint/Non-Restraint: Part I, Changing Attitudes; Part II, Assessment and Alternatives.* The video includes interviews with representatives of each category of staff member on two nursing units that had implemented the non-restraint philosophy: patient care aides; activity workers; licensed practical nurses; registered nurses; head nurses; an instructor; and the director of nursing.

Survey of restraint use: Before showing the video production and implementing the policy and procedure, we did a pre-implementation audit of restraint use in the medical, surgical and geriatric nursing departments of the hospital. Of the 1104 patients observed, 142 (13.6 percent) had some type of physical restraint in place. Of the restrained patients, 86.5 percent were over 60 years of age, and 80 percent were over 70 years of age. These findings are similar to a recent study at the Sunnybrook Medical Centre in Toronto.[7] We plan two further audits six and twelve months after implementation of the policy and procedure.

Abrégé

L'adoption d'une philosophie de non-contention. L'emploi abusif des moyens de contention, tout particulièrement dans le cas de patients âgés, est un point qui intéresse les infirmières depuis longtemps. L'Hôpital général de Vancouver a adopté une philosophie de non-contention qu'il fait appliquer peu à peu. L'énormité apparente de cette tâche est traitée en trois étapes, ce qui permet à tout établissement intéressé d'adopter une philosophie semblable. Ces étapes sont les suivantes : formation d'un groupe central; essai dans un service; et mise ne œuvre dans l'ensemble de l'établissement.

Implementation: To communicate the implementation of the policy to the nursing division, I presented the philosophy at Nursing Forum, a weekly, one-hour session open to all members of the nursing division. These sessions are well attended by nursing staff, head nurses and nurse executives. The policy and procedure outline was distributed to those attending the session as they entered the auditorium. I gave a brief overview of the project, showed the video and opened the floor to questions and comments.

Nursing staff again expressed concern about legal liability of themselves and of the hospital. It was particularly helpful, as before, to have a head nurse present who had been through the process and found it to be a positive experience for all concerned—herself, her staff and the patients and their families.

We were careful not to make the nursing staff feel guilty for current use of restraints. They also needed to know we were not advocating total absence of restraints. Restraints are needed in some cases. Yet, we encouraged nurses to be especially careful about restraining elderly patients. It is with these patients that restraints tend to be overused, and once in place they often are not removed; the restraints become accepted and their continued need is seldom assessed.

In the week after Nursing Forum, the new *Restraint/Non-Restraint of Patients* policy and procedure guideline was circulated to the nursing units along with a notice that 10 copies of the video were available on loan from the staff development department. We included a packet of supplemental information: a list of activities to promote patient safety when using a non-restraint philosophy; a pamphlet—*Nursing Guidelines for the Use of Restraints*—produced by the Massachusetts Nurses' Association; and a journal article entitled "About Using Restraints—with Restraint."[8]

We hope our six- and 12-month post-implementation audits of restraint use in VGH will indicate the impact of our video, our policy and procedure guide and our success in implementing a major change in nursing practice.

A reconstituted core group of nurses continues to work on restraint issues. In the fall of 1988 we began work on finding or creating a tool to assess patients' risk of falls and falling. We are also preparing a more comprehensive guide for alternatives to restraints. We believe a philosophy of non-restraint *can* be put into practice. ☐

The videotape *Restraint/Non-Restraint* (29 min.) is available for preview, rental or purchase from Magic Lantern Film Distributors Ltd., 136 Cross Ave., Oakville, Ontario L6J 2W6.

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The National Center for State Long Term Care
Ombudsman Resources
2033 K Street, NW, Suite 304 • Washington, DC 20006 • (202) 785-1925

EXCERPTS FROM

AN OMBUDSMAN'S GUIDE TO EFFECTIVE ADVOCACY
REGARDING THE
INAPPROPRIATE USE OF CHEMICAL AND PHYSICAL RESTRAINTS

with an

IN-SERVICE TRAINING GUIDE FOR OMBUDSMAN
REDUCING INAPPROPRIATE RESTRAINT USE

DRAFT
Prepared

For The National Center for State Long Term Care Ombudsman
Resource Center

October 1989

by Sarah Burger

NATIONAL CITIZENS' COALITION FOR NURSING HOME REFORM
1424 16th Street, N.W., Suite L2
Washington, D.C. 20036
202/797-0657

DETRIMENTAL EFFECTS OF PHYSICAL (PR) AND CHEMICAL (CR) RESTRAINTS ON RESIDENTS

Developed by the
National Citizens' Coalition for Nursing Home Reform
for the
National Center for State Long Term Care Ombudsman Resources
funded by the
Administration on Aging

EFFECT	CAUSE	PREVENTION
SKIN		
Bruising/cuts/redness (PR)	Incorrectly applied restraint or improper size or type of restraint. Resident struggles against restraint	Apply restraint correctly according to manufacturer's direction Use alternative methods. Apply restraint for short periods only.
Pressure sores (PR/CR)	Resident in one position too long. Studies show two times number of pressure sores in restrained residents.	Release, exercise, at least every 2 hrs.- oftener if necessary. Use alternative methods.
PSYCHOLOGICAL		
Panic/ anxious expression/ combative/ increased confusion (PR/CR)	Frightened by PR. Does not like restraints. Does not understand why they are being used. Paradoxical reaction to a psychoactive drug; that is, it has the opposite effect intended.	Use alternative methods. Use CR and PR for short periods only. Use different drug, lower dose or no drug.

EFFECT	CAUSE	PREVENTION
Lethargy/depression/ decreased social interaction (PR/CR)	Person gives up when restrained, withdraws, broken spirit. Staff ignore restrained resident. Drug in too large dose.	Use alternative methods. Increase opportunity to socialize. Frequent staff interaction. Decrease time restraint used. Decrease drug dose or change drugs.
Screaming/yelling/ calling out (CR/PR)	Use alternative options, identify and meet needs, comfort	Use alternative options, identify and meet needs, comfort
GASTRO-INTESTINAL GENITO-URINARY		
Decrease in appetite/ weight loss/sunken cheek bones/ sores around mouth (CR/PR)	Broken spirit/not interested in life. Discomfort of restraint/preoccupation with discomfort. No activity to work up appetite. Too drowsy from drug use to eat.	Use alternative methods. Release, exercise at least every two hours. Decrease drug dose.
Dehydration Dry skin/dry mouth/ sunken eyes/ fever/ acute confusion. (CP/CR)	Cannot reach water. Too drowsy to drink. Too depressed to drink. Does not recognize decreased sense of thirst.	Use alternative methods. Leave water within reach at all times. Offer fluids/ encourage to drink between meals and at meals.

EFFECT	CAUSE	PREVENTION
Urinary Retention Distended lower belly/complains of needing to go to the bathroom/ dribbling when toileted instead of good stream/ presence of catheter with no other apparent cause. (CR)	Many psychoactive drugs effect ability to release urine.	Discontinue drug. Use alternative methods. Use alternative drug. Discontinue catheter use.
Incontinence Wet/ complain of not being taken to the bathroom/ agitation especially for resident with dementia/presence of catheter for no other apparent reason (CR/PR)	Not taken to bathroom/toileting done according to facility rather than individual pattern/drug action may cause incontinence	Release, toilet, exercise every two hours or more often if necessary Use alternative methods Discontinue drug Use alternative drug.

EFFECT	CAUSE	PREVENTION
Urinary Tract Infections (CR/PR) Pain and frequency of urination, fever	Catheter use, not voiding regularly, low fluid intake	Toilet to avoid incontinence, increase fluid intake, use alternative methods
Constipation/ impaction Resident complains of stomach ache/ constipation Restlessness Decreased appetite/ confusion Preoccupied with bowels (CR/PR)	Lack of activity Inability to get enough fluids Not taken to bathroom according to lifelong bowel pattern.	Release, exercise, toilet every two hours or more often if necessary. Toilet according to lifelong pattern Offer fluids between meals and at meals Leave water within reach Use alternative methods
RESPIRATORY		
Resident complains that chest feels tight/says "can't breathe"/appears anxious	Chest/ vest restraint is too tight. Resident fears restraint and has anxiety attack Lack of movement	Use alternative methods Loosen restraint Decrease use of drugs Exercise every two hours or more often if necessary
Pneumonia (CR/PR) Acute confusion/ shortness of breath/ chest pain	Lack of movement allows secretions to pool, decreases efficiency of lungs with decreased oxygen exchange and increase confusion. Shortness of breath when active	same as above

EFFECT	CAUSE	PREVENTION
Death (PR)	incorrectly applied restraint leads to death by strangulation	Apply restraint correctly/ use alternative methods.
CARDIOVASCULAR		
Swelling of ankle or lower leg/rings too tight/shoes too tight.	Older people may have a less efficient circulatory system. Without enough exercise,and changing of position fluid collects in hands and feet.	Release, Exercise every 2 hrs/ change position often. Lie flat in bed every two hours. Use alternative methods.
Death	Cardiovascular stress response as fearful resident struggles to be free from restraint.	Use alternative methods. Meet individual needs of resident.
MUSCULO-SKELETON		
Decrease in mobility such as unable to walk, move own wheelchair. Wasting of muscles over time. Contractures in extremities recognized by hands in fist, bent elbows,knees bent toward chest and moved, if at all, only with difficulty and pain. Increased fractures.(CR/PR)	Prolonged inactivity causes loss of muscle in all ages, so that the person gradually loses ability to use them; bone loss results in increased fracture risk.	Use alternative methods: physical therapy, release, weight bearing exercise every 2 hours or more often if necessary. Range of motion exercises, fit chair to individual, use cushions, wedges and pillows for comfort.

PRINCIPLES OF REDUCING INAPPROPRIATE CHEMICAL AND PHYSICAL RESTRAINT USE

Ombudsmen can use these principles in advocating for staff to use better care for all residents. Restraints use is generally poor care practice; in addition, restraints mask the unmet need of the individual resident.

1) Individualized Assessment: An in-depth assessment by an interdisciplinary team is the basis for discovering resident needs and strengths. OBRA requires that the assessment be coordinated by a registered nurse with the appropriate participation of health professionals. Other professions might include Dietitian, Physical and/or occupational therapist, Social Worker, and Activities Professional. The Health Care Financing Administration contracted with the Research Triangle Institute to develope an assessment instrument. The OBRA mandated assessment will include customary daily routine and individual preferences of the resident prior to nursing home admission. In addition activities of daily living, mood, attitude, memory, communication, disease states and medications as well as activities are assessed. Both the resident and nurse aides are interviewed when this assessment instrument is used.

2) Individualized Care Plans: Care plans must meet the needs identified in the individualized assessment. (See handout: "Options for Action to Reduce Inappropriate Use of Chemical and Physical Restraints.") Care planners include the resident, family and nurse aides in addition to professional staff.

3) Teamwork: Teamwork from professional and non-professional direct care-givers, indirect care-givers, volunteers, family and other residents is necessary to reduce inappropriate restraint use. No one group or discipline has all the answers.

OPTIONS FOR ACTION TO REDUCE INAPPROPRIATE PHYSICAL AND CHEMICAL RESTRAINT USE

What are the options for action? [staff may not know other ways to care for residents and will need specific suggestions on how to meet resident needs in order to reduce restraint use. Ombudsman may advocate for nursing homes to use any combination of these options. Resident needs change over time, therefore, the combination of options is constantly changing.]

(1) Companionship and supervision including the use of volunteers, family, friends, other residents etc.
(2) Physical and Diversionary activity such as exercise, time outdoors, activities that truly reflect what the resident would like to do, and small jobs agreed to by the resident.
(3) Psychosocial interventions including ferreting out information about lifelong habits and patterns of daily activity which must then be incorporated into the care plan.
(4) Environmental manipulations such as alarms or other system for keeping track of those who need to wander, using ribbon barriers on doors of resident rooms so wandering residents won't come in uninvited, good lighting, mattress on floor so pad possible fall, individualized seating and furniture placed to aid in ambulation, use of low beds.
(5) Meeting identified physical needs such as hunger, toileting, sleep, thirst and exercise according to individual routine rather than facility routine.
(6) Staff attitudes and training to teach how to identify needs and then to meet them on an individualized basis.
(7) Staffing levels high enough to comply with the law which requires enough staff to meet residents mental, physical and psychosocial needs. These can be met by use of heavy staffing during peak busy periods of the day.
(8) Administrative support so that flexibility in routines is the norm in order to accommodate individual needs.

Scientific/Technical
Session 104-A

Cynthia F. Epstein

Patricia M. Sadownick

Specialized Seating for the Institutionalized Elderly

Prescription, Fabrication, Funding

Out-of-bed seating for the severely involved, institutionalized elderly is of major concern to occupational therapists. Technological advances have provided multiple options for wheelchair adaptations, some of which can be quickly and effectively used by the therapist on site. Other more sophisticated adaptations require fabrication and assembly through a vendor. The expanding array of equipment, materials, and supplies requires increasing familiarity with available options so that knowledgeable decisions can be made. Appropriate prescription and fabrication must be followed with adequate funding. Therefore, today's therapist must be equally skilled in identifying funding streams and obtaining the necessary monies for specialized equipment and adaptions.

Evaluation and prescription issues for out-of-bed seating must consider both the needs of the individual client and the readiness of the facility to accept complex and variable components in a seating system. A support team within the institution must be committed to effective use and maintenance of the specialized seating provided for the client. Without team cooperation the seating system, carefully and knowledgeably designed by the therapist, will not be used effectively—if at all! An important part of the evaluation process for the therapist must therefore be consideration of the human and non-human environments

Cynthia F. Epstein, MA, OTR, FAOTA, is the Executive Director of Occupational Therapy Consultants, Inc., Bridgewater, NJ.

Patricia M. Sadownick, MS, OTR, is Director of Occupational Therapy at Clove Lakes Nursing Home and HRF, Staten Island, NY.

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which support the positioning program designed for the client (Epstein, 1988).

The complex problems in providing seating for this elderly population require that the therapist have space, appropriate supplies, and access to special equipment in order to evaluate the client during several sessions. Without such resources, subtle issues that affect functional positioning may be missed, thereby causing serious problems after delivery of the system. As an example, a client with agitated behavior on the nursing unit may be characterized by repetitive movements of the lower extremities. Using an unpadded laptray as part of a seating system for such a person places them at risk for bruises and tears of the skin.

Supportive environments for the therapist and client within the institution must be complemented by a pool of knowledgeable vendors and an understanding of funding options. Use of specially designed forms, such as the one recently developed by a seating/wheeled mobility task force (Electronic Industries Foundation, 1988), will help assure approval of costly equipment.

Prescription

Institutionalized elderly present complex evaluation issues. Staff referral for positioning may be made due to "constant sliding out of chair." The therapist's concerns, however, are multiple and specific. Such factors as tone, posture, skin integrity, continence, sitting tolerance, and movement are primary. Orthopedic considerations, including kyphosis, scoliosis, dislocated hips, flexion/extension deformities, must be delineated. Complex diagnoses, including osteoarthritis and osteoporosis, and long histories which may include fractures, decubiti, multiple bruises, and skin tears are of concern. Functional abilities to perform such tasks as self-propulsion, transfers, eating, communication, and participation in activities must be ascertained (Gans, Hallenborg and Trefler, 1984).

Evaluation considers the methods for normalization and stability, beginning at the pelvis. Such problems as obliquity, tilt, and fixed deformity require seat and back modifications. These may include a seat with a special cushion, hip guides, abduction wedge, anti-thrust roll, seat belt, or bar across the anterior-superior iliac spine (Cooper, 1987; Margolis, Wengert & Kolar, 1988). The sling back may be replaced with a firm back and contoured with pressure responsive foam, lumbar or shoulder rolls, lateral supports, and possibly a specially designed headrest (Bergen and Colangelo, 1982). Significant scoliosis and kyphosis require more supportive environments, such as those available through Contour-U and Foam-In-Place Systems (Bergen, A., 1988; McNaughton, K., 1988). Angulation/Orientation-in-space, now available for the adult population, must also be considered for those in need of gravity assistance to maintain a stable and normalized seated position. Such equipment allows control and appropriate positioning for head, trunk, pelvis, knees, and feet (Rego, 1988).

Severely involved, institutionalized elderly are at high risk for pressure sores. Seat cushions must therefore be responsive to the particular needs of the individual (Garber, 1979, 1985). A wide variety of wheelchair cushions are available, giving the knowledgeable therapist many options and a varied price range.

Fabrication

The standard size wheelchair, found in most institutions, can easily serve as a basis for adaptive seating inserts. These adaptations can be fabricated within the occupational therapy department or with the assistance of the facility's maintenance department. More complex seating will require the efforts of a seating team and fabrication by an outside vendor. In either case, the therapist must be knowledgeable regarding the variety of materials and component parts that are available on the market to provide the needed adaptations.

Low-tech adaptations allow a therapist on-site gradually to modify the wheelchair while monitoring the client's response to each change. As long as the modifications are simple, easily applied, and understood by staff, they are well accepted and provide a quick, inexpensive, and effective solution.

Materials such as plywood; polyurethane; viscoelastic and ethafoams; hook and loop or webbing straps; and special hardware, fabric and vinyls offer many creative solutions to the knowledgeable therapist (Shafer, A. & Epstein, C., 1987).

Inexpensive, commercially available adaptions are also available to assist therapists in quickly resolving positioning issues. Simple to apply, easily understood by staff, and fabricated to withstand use in an institutional setting, these positioners are cost-effective solutions and can be kept in stock as part of the occupational therapy supplies (Epstein, C. E., 1988; AliMed, 1988).

Those clients requiring more complex seating should be seen by the seating team in conjunction with a knowledgeable medical equipment dealer. Decisions regarding linear vs. contoured, upright vs. angulation in space, fixed vs. adjustable hardware, foam vs. gel, and multiple other options can be considered by the team as they observe client response to seating modifications (Randall, M., 1984; Treller, E., 1984). It is preferable to simulate the projected seating environment so that client response can be assessed over a number of days.

Funding

Without funding, the time, energy, and multiple resources devoted to prescription and fabrication will be for naught. Inexpensive and readily available adaptations require support from within the facility. Funds may be provided through nursing or maintenance budgets, or directly to the occupational therapy budget. In some cases, it is possible to have client families support the needed equipment.

For more expensive and complex equipment, funding is sought through third-party payors or client families. When third-party payors such as insurance companies, Medicare, and Medicaid are involved, a comprehensive report and justification for the needed equipment are required. A well-written, clearly presented report with accompanying pictures and data on comparative equipment that was considered but not recommended will help to obtain approval for costly inserts. In addition, the use of a facility wheelchair frame, into which the insert can be fitted, will go far in obtaining the needed approval.

Summary

Today's technological advances in seating allow therapists servicing institutionalized elderly to provide effective positioning for this needy population. Clients who are well positioned will increase their participation in and functional performance of important self-care skills. Interaction with the environment, awareness, and communication with peers and staff will increase. Staff support and interest in these severely involved elderly will be enhanced in direct response to the client's greater independence and the decreased staff time required for repositioning.

Using "low- and high-tech" approaches to seating, the creative and knowledgeable therapist can expand services to this population. Funding sources from within the institution, as well as from client families and third-party payors, will help maximize the amount of adaptive seating available in any given facility.

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Programs And Services Which Specialize In The Care Of Persons With Dementing Illnesses—Issues And Options

Nancy Mace, MA

Introduction

Alzheimer's disease has skyrocketed from obscurity to "disease of the year" status and, in response, an array of programs and services which specialize in the care of people with dementia has developed.

A growing body of clinical knowledge indicates that people with dementing illnesses probably need unique interventions which differ in some respects from the care needs of people with other chronic illnesses. Nursing homes, domiciliary care units, adult day care programs, and in-home providers are responding to this by specializing in the care of those with dementing illnesses.

People with dementia who have participated in some of the innovative programs have shown tantalizingly dramatic improvements in social function and quality of life. Families who have participated in respite programs report being able to continue to provide care at home with less stress.

Providers see a market for special programs, and families, desperate for a better answer for their loved ones, support these programs. At least one state has waived restrictions on the construction of new nursing home beds when these beds are intended for persons with dementia—thus adding political pressure to the existing market forces. Both the public and private sectors have funded research and demonstration programs in specialized respite care.

This rapid development of specialized care has led to difficult and unanswered questions.

1. Should there be separate segregated care?
2. Who should receive specialized care?
3. What benefits can we expect from specialized care?
4. Can we describe a model of specialized care that is preferred for people with dementia?
5. How can we ensure quality of care in these programs?
6. How do issues of cost affect the kind of care that is available?

These are difficult questions. Decisions made now will influence the patterns of care for thousands of people for many years. These questions have triggered heated debate and strong opini-

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Nancy Mace, MA, is co-author of ***The 36 Hour Day, A Family Guide to Caring for Persons With Alzheimer's Disease, Related Dementing Illnesses, and Memory Loss in Later Life****, and a member of the Board of Directors of the Alzheimer's Disease and Related Disorders Association.*

The author wishes to express her appreciation to Nancy Orr, MSG, Director, Hillhaven Special Care Units and Rachel Billington, Associate Executive Director, Alzheimer's Disease and Related Disorders Association for their critique of this article.

ons, but to date there has been very little research to provide answers and clinical experience has been mixed. This article will define some of the issues.

I. Should there be separate, segregated care?

Table 1 summarizes some of the pros and cons of special programs and units, but it is evident that these arguments address several separate issues.

1) Issues of good care must be considered separately from issues of separate care. Most patients, including those with dementia, would benefit from some of the changes advocated for special care. The question must be: when care is good in both integrated and segregated settings, which is better?

2) Issues vary by setting (for example, the social benefits of group programs do not apply to individual home care.)

3) Issues vary with characteristics of the recipient. (for example, the person with a late stage dementia and multiple illnesses might not need segregated care that could benefit an ambulatory person.)

Some of the arguments in Table 1 make the point that there should be separate, segregated care because it is beneficial. To evaluate the merits of these arguments we must consider who benefits from special care.

Specialized care may benefit the patient: may benefit the family (by providing respite); may benefit the residents of a facility who are not cognitively impaired; may benefit the provider (by opening a new market), or may benefit the taxpayer (through cost savings). Care might benefit the patient, but cost the taxpayer or family; or it might benefit the facility more than the resident. Important value judgements may ultimately have to be made. Those who make such decisions will need accurate information about real benefits objectively presented.

> ***Issues of good care must be considered separately from issues of separate care. . . The question must be: when care is good in both integrated and segregated settings, which is better?***

At present, however, not enough is known to provide such information. The most dramatically successful approaches to care have been with small groups of patients and their experiences have not been adequately tested or replicated. We do not know whether other patients or families would benefit as much. We do not know how easily these programs can be replicated on a larger scale. Small projects carried out by dedicated people do not always work as well in the huge impersonal long term care system.

II. Who should receive special care?

Because there is no single funding mechanism or licensing authority for programs which have specialized in dementia care, it is almost impossible to identify the number of programs which have specialized: whether they are nursing homes, domicilary homes, foster homes, adult day care, short stay respite, in-home care, or other innovative initiatives. Few generalizations can be made about who is providing care or who is being served. Moreover, specialized care is growing so rapidly that it is difficult to keep up with new programs.

It is estimated that 40-80 percent of persons in nursing homes suffer from cognitive impairments[7] (and a much lower percent of people in respite care programs have dementia), yet only a few are selected for special care. Should everyone with dementia receive special care, or if not, what criteria determine special care needs?

Some specialized respite programs limit service to patients who are ambulatory, continent or non-combative. Home care programs may serve incontinent, bed bound patients or refuse only combative patients. Residential programs say they elect participants who have "behavior problems", or "who are not working out" on regular units. Programs may restrict admission to those who "can participate" or who can "participate in self care and follow simple instructions". Thus, although few firm criteria have been established, programs are tending to select participants in the middle stages of their illness. Some staff believe that these patients benefit most from special care, that other residents and staff benefit from their removal from a mixed unit, and that families benefit from respite. Yet, almost nothing is known about how much people in the early stages of dementia, or in the late stages would benefit from special care.

Finally, other factors which have little to do with the appropriateness of the client for the service

Table 1. Arguments for and against special programs/units for persons with dementia.

FOR	AGAINST
Some special programs have found that trained staff in a special environment and a homogeneous group of clients produce measurable evidence of benefit in some people with dementia.	The needs of demented patients are the same as the needs of other long term care recipients. The problem is not one of providing different care, but of providing better care.
In addition to the changes which benefit all patients, specialized interventions can further benefit people with dementia.	Many of the changes needed by people with dementia are needed by all long term care recipients.
Being around people whose mental functioning is higher can be stressful for persons with dementia who must constantly struggle to process even simple information.	Placing dementia victims with cognitively well persons helps the person with dementia to stay alert by providing role models. Isolation in dementia units may lead to greater deterioration.
Specialty units permit special interior design, fire safety equipment, trained staff and marketing efforts to attract private pay clients. The demand for quality ensures that beds in good facilities will fill quickly.	In areas with low population density, there will not be enough persons with dementia to support special programs, particularly day care. When families must travel long distances, they may visit less often.
The current demand for specialized units is such that families will transport patients long distances for residential care.	Specialty units must hold a bed open until a person with dementia needs it. This is more expensive than quickly filling beds with the next available client.
In several informal surveys cognitively well elderly people have made it clear that they do not want to spend their lives with persons who act "crazy" or are disruptive. The lucid client is vulnerable to loss of privacy, loss of personal property, interrupted sleep and fear of harm by the agitated person. Efforts to protect the lucid client result in over-medication and restraints which have negative effects on persons with dementia.	In mixed units, the cognitively well can help look after the person with dementia, allowing lower staff ratios and giving the well client something to do.
There are ethical issues involved in using persons who are paying for their own care as supervisors of other patients and disgruntled people make poor role models.	
Abuses are issues for consumer education and industry regulation (voluntary or enforced).	Some existing dementia units or programs are not offering anything special—except using this label as a marketing tool or justification for higher prices.

are also involved in selection of clients for special care: ability to pay, ability for reimbursement for care, or proximity to the program. Caregiver need is also a factor, and for respite care, may be more important than patient characteristics for respite care.

Thus, at present we know little about who is providing or receiving specialized care and almost nothing about who *should* receive it.

III. What benefits can we expect from specialized care?

One of the most controversial issues and perhaps the one most important to family members is whether (and how much) participants will benefit from special programs. Some argue that because the most common causes of dementia are irreversible, no benefits can be expected. A few make the claim, as yet unsubstantiated and not accepted by leaders in the field, that special programs slow or reverse mental deterioration. In between are those who point out that supportive environments can significantly improve some aspects of life for the patient or caregiver.

Respite care is widely believed to benefit the caregiver, and many argue that it delays institutionalization by enabling the family to care longer.

The benefits of respite care to caregivers are obvious to staff and families. However, so far they have proven elusive to document. To date, studies have not rigorously compared the impact on families participating in respite programs with matched families who have not. However, both the public and the private sectors are now launching good studies of the effect of respite care on caregivers.

Programs have claimed a variety of improvements in their cli-

FOR	AGAINST
An all-dementia unit allows staff to develop expertise in patient care. This benefits patients and is rewarding to staff. Experience has shown that staff do not necessarily "burn out".	Staff will quickly burn out on a dementia unit.
The issue of "burn out" and staff satisfaction is not unique to dementia care, but reflects pervasive problems in the long term care system.	
Patient rights laws, ombudsmen, and quality assurance regulations assure oversight of persons who are not competent. The new focus on dementia reduces the risk that patients would be poorly served.	A program serving persons with dementia would create a ghetto in which no one would be able to report abuses or be a legally competent witness. Ombudsmen rarely serve respite or domicilary care programs. Dementia patients often outlive the families who advocate for them, and employees may be afraid to complain.
Dementia is a medical speciality long overdue for recognition. Speciality programs would attract physicians and nurses interested in this field.	Dementia is not a medical specialty, deserving of separate designation and specialization, because the needs of these individuals are primarily psychological and social.

ents (see Table 2). In general, these programs have examined small groups of patients, without the use of rigorous measures of change, and without a control population (e.g. similar patients not receiving special care).

Instruments which document the stage of the illness, the impairments of the patients, or behaviors would make it possible to compare the effects of certain programs or the impact on certain subgroups of participants. Many of the tools for measuring impairment in function are not sensitive to subtle changes. The existing staging instruments apply only to uncomplicated Alzheimer's disease and their validity and reliability remain controversial. Behavior is notoriously susceptible to environmental variation, making it difficult to separate the effects of intended change from other factors.

We have a limited knowledge of the natural history of the behavioral components of each of the dementing illnesses. We need to know what behaviors are exhibited by all, most, or only a few people in order to demonstrate that a program reduces the incidence of these behaviors. Do all patients wander? Does wandering come early or late? What percentage of patients become combative or remain ambulatory until close to death?

The most commonly reported improvements fall in two categories:

1. Changes that may have resulted from the removal of excess disabilities. Excess disability can be defined as greater disability than can be explained by the disease alone. Frequently cited causes of excess disabilities include medication reactions, concurrent illness, stress, and sensory impairment.[7]

2. A second common area of reported improvement is in social function. This may include more socially appropriate behavior and formation of peer friendships with other participants. Few programs have claimed improvements in memory, language, object recognition, or praxis and most report that their client's dementia continues to progress.

Most of the programs that make some appropriate changes in the patient's physical and psychosocial environment, regardless of which changes are made, report improvement. This encouraging finding may be because very impaired people may be more vulnerable to their environment, and therefore more responsive to even slight improvements.[5] This observation and the frequency of reports of participant response supports the position that the quality of life can be improved for a significant number of people with dementia. The kind of changes reported are desirable from the point of view of the patient, the family and the staff. It is therefore worthwhile to attempt to define the best possible care for people with dementing illnesses and to identify the factors that make life as satisfactory as possible for them.

IV. Can we describe a model of specialized care that is preferred for people with dementia?

Some argue that enough information exists to define a standard of excellence. Other argue that it is premature to take any position on the nature of these programs. A review of the current state of knowledge indicates that there is a responsible middle road.

Many providers agree that there are certain "best practices" which are inarguable, but not universally practiced. Most of these are not unique to the care of people with dementia, but apply to the care of all frail, ill individuals. However, both long term care providers and acute care providers sometimes fail to observe these practices. Cognitively impaired people may be exceptionally vulnerable to their omission. What follows is neither comprehensive nor inarguable, but a few suggestions for consideration:

- Obtaining a medical history and a personal history that includes management techniques, likes, dislikes, interests, fears, hobbies, former profession, people in the person's life that he or she might ask for.
- Development of an individualized care plan that includes (as appropriate) medical, nursing and psychosocial goals with input from multiple disciplines and, where possible, is discussed with the family. Periodic revision of the care plan, and communication of the plan (or appropriate sections) to all staff involved in care, is essential.
- Specialized training for staff which reflects the current thinking about communicating, relating and supporting patients, clients and their families.
- A planned system of effective communication among staff and caregivers, including all shifts, all disciplines and the family—if there is one.
- Advance discussion with appropriate family members regarding the use of life supports and aggressive interventions at the end of life.
- Provision of respect and dignity. It can be difficult to communicate respect and dignity toward ill and impaired people. However, the institutional environment and techniques of staff approach to patients can be examined for those things which communicate loss of personhood, dignity, roles, freedom and identity. Some of these are amenable to change, and the program should be actively involved in efforts to identify and modify them.
- A planned approach to patient rights and quality of life which takes into consideration the special handicaps of people with dementia.
- A planned approach to provision of safety that includes protection for wanderers, protection against injury or falls, and fire safety (people with dementia may not respond to a fire alarm or may wander back into a facility if left alone.) The plan must have weighed the need for freedom, mobility and maintenance of function against the risk of injury.
- Provision of medical and nursing care (with specialty consultation when needed) that manages, treats and reviews medication use and concurrent illness, to the extent that patients do not suffer from such excess disabilities or delirium as can be reasonably prevented. Psychoactive medications should be used only for the patient's benefit, be closely monitored, and never used as a substitute for staff time or training.
- Provision of activities which are meaningful to the participant, are enjoyable, give satisfaction, allow experiences of success, sustain old roles, and which significantly reduce the number of empty hours the patient experiences.
- Recognition that the family is

Table 2. Behavior changes in persons with a dementing illness reported by programs which specialize in care of persons with Alzheimer's disease and related disorders.

- decrease in wandering (Sawyer and Mendlovitz, 1982; Coons, 1986);
- decrease in episodes of agitation (Coons, 1986; Hall et al, 1985);
- no screaming or a decrease in screaming (Hebrew Home for the Aged of Riverdale, 1986);
- few or no drugs needed to control behavior (Hall et al, 1985; Coons, 1986; Sommers, 1985)
- improved orientation (Coons, 1986; Sommers, 1985);
- decrease in socially unacceptable behaviors (masturbation, rummaging in other patient's rooms, etc.); (Coons, 1986; Sommers, 1985);
- weight gains or improved eating (Hall et al, 1985; Coons, 1986; Sommers, 1985);
- decrease in depression (Coons, 1986);
- greater ability to sleep through the night (Coons, 1986; Hall et al, 1985);
- a sense of humor (Coons, 1986);
- a happy, relaxed appearance (Coons, 1986; Hall et al, 1985);
- the formation of friendships (Coons, 1986; Hall et al, 1985; Mace and Rabins, 1984);
- reduction or elimination of incontinence (Wells, 1986; Coons, 1986);
- the initiation of interpersonal exchanges (Coons, 1986); and
- decrease in hallucinations (Hall et al, 1985).

Source: Office of Technology Assessment, U.S. Congress "Losing a Million Minds: Confronting the Tragedy of Alzheimer's Disease and Other Dementias." (Washington, D.C., April, 1987) the second victim of dementia and provision of family support which may include referral, education, support groups, improved visiting skills, or improved home care skills.

Several models of care are being suggested: the medical model, the nursing model, the environmental model, the activity model, etc. Nowhere are the artificial distinctions between models less appropriate than in the care of persons with dementia. The need for an integrated model is clear.

People with dementia are ill and their symptoms can be exacerbated by other illnesses or reactions to medication, therefore they will need medical care. Like others with chronic illness, they have social, psychosocial and recreational needs which are best met by people skilled in these areas. Since no clinically therapeutic drugs are available they also need a care model which stresses environmental support. The relationship between these needs differs with the individual and the progress of his illness. Few would argue that the care needed is a multidisciplinary approach model which provides balanced care appropriate to the patient's changing needs.

In addition, there is a body of knowledge about the changes that occur with aging, the effects of sensory loss, cognitive function and the management of certain symptoms which should be applied to the care of persons with dementia. (Not all persons with dementia are elderly nor have all experienced sensory loss, but many will benefit from these interventions.)

V. How can we Ensure Quality in These Programs?

There is little doubt that people with dementia are vulnerable to

Support of Sensory Function. A considerable amount is known about the common sensory deficits of late life and about ways to modify the environment to support normal function.[2,5] We know the lens of the eye yellows with age, vision can be affected by disease, hearing, taste and smell may be impaired. We know that arthritis can make a person so stooped that he or she is looking not at the identifying door decorations but at the floor. There are strategies to support remaining sensory function, yet we often fail to apply this information to people with dementia. People whose cognitive abilities are limited should not also be expected to compensate for sensory impairments in a nonsupportive environment.

Environments can be shaped to support or impede social function.[2,5] Aimless wandering can be redirected into a pleasant and safe experience. A bathroom can be made easier to locate; people who must sit in wheel chairs can be made more comfortable.

Support Interpersonal Communication. People with dementia who have difficulty with language often remain sensitive to non-verbal communication. Professional caregivers can learn to avoid negative nonverbal messages and to communicate affection, respect, and the continued usefulness of the impaired person.

Support Remaining Function. We understand some of the ways that dementia affects thinking, response, perception, and other cognitive functions.[8] We can apply this information from neuropsychology to methods of care by limiting demands on impaired capacities and calling on remaining skills. When short term memory is impaired, we reduce demands on it. When language skills deteriorate and the ability to do previously learned motor tasks is lost, we avoid fine motor tasks or those requiring verbal skills and offer activities which use gross motor skills and retained social skills. Since patients sometimes perseverate—that is they get stuck on one movement or focus—we must help them to change focus. Since tolerance for frustration is low, we offer activities that increase experience of success.

Provide Stimulation but Not Stress. Both low stimulus environments and high stimulus environments have been proposed. People with dementia are often susceptible to stress and may overreact to even mild stressors. Even the familiar home environment may precipitate catastrophic reactions. However, the institutional environment may be so barren that the resident is almost "bored to death" and people with dementing illnesses are often unable to initiate or sustain meaningful activities independently.

Stress and stimulus are not the same thing. A low stimulus environment may be stressful if it fails to provide good sensory clues and satisfying things to do. At the same time, an environment that is comfortable for a cognitively well person may offer too many stimuli for an impaired person. The goal is to provide an environment that limits stress but is rich in enjoyable experiences, sensory pleasures, and things to do that offer self esteem and social interchange.

Individualized Care. We know that there is great variability among persons with Alzheimer's disease. There is also a variability between people with Alzheimer's disease and people with other dementing illnesses. It is clear that we cannot successfully apply care techniques across all people with dementia. Some will have poorer eyesight and better hearing; some will have good fine motor skills and limited language skills. Some lose the ability to recognize objects or family members; others retain this ability for a long time. Care cannot be an assembly line affair: good care will require knowledge of the individual's wishes, his spared and impaired abilities, his prior history, and his family. Individualized care probably also helps to sustain a sense of identity and personhood.

Treat Treatable Symptoms. Psychiatric interventions can help people with dementia who have delusions, hallucinations, depression or severe agitation. Pharmacologic interventions probably relieve these individuals of inner torment. Few would argue that the best practice means the judicious use of psychotropic medication by a physician experienced in such care, after an evaluation of the problem. These drugs usually should not be used on an as needed basis or as a substitute for staff time, therapeutic activities or medical care.

The Questions that Remain. Generalized best practices and knowledge about medical care needs, sensory deficits and supportive environments is only part of the answer to the question, "What is the best model of care for people with dementia?" A wide variety of hypothesized interventions remain experimental and controversial.

People with dementia are difficult to take care of and varied in their response to interventions. Application of the knowledge we have is difficult. Exactly how is stimulation balanced against too much stress? Will these people do better in small, stable groups? Which activities build self-esteem? Knowing that a program should provide successes and avoid failures is far different from figuring out how to help a specific group of severely impaired or frightened people. As any nurse's aide or family member can testify, theory will not get Mr. Brown to take a bath.

We do not know how much improvement to expect for people with dementia, nor how many or which people are most likely to benefit. Are existing programs doing well or are they falling short of what is possible? Is success due to the capabilities of the participants or the skills of a particularly charismatic clinician?

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poor care. They cannot remember and report mistreatment. Their disability means that they cannot obey a fire alarm or safety instructions. In addition, family members are complaining about programs which advertise "special" care, but in fact offer nothing exceptional.

Ensuring quality in long term care is a complex issue and one which has not been resolved.[3] Families need to inform themselves about the issues and problems of ensuring quality care in nursing homes, domicilary care, in-home care and adult day care. In each setting, the problems are different. In some cases, existing standards are not enforced; in others, standards are not appropriate for people with dementia, and in others, standards are almost nonexistent. It makes sense to ensure existing standards, or to create appropriate general standards before imposing special criteria for dementia care. Serious problems exist in our current system; vigorous advocacy would benefit patients with dementia.

Since much remains unknown about ideal models of dementia care, standards, or guidelines which encourage a specific model could discourage innovation.

VI. How do issues of cost affect the kind of care that is available?

Discussions of models of care are often tied to discussions of cost. There is concern that an ideal model of dementia care would be prohibitively costly for such a large population. Much could be written on what is not known about the cost of care. For example, the relationship between quality of care and cost is not necessarily a direct one. More costly programs will not necessarily provide better care; however, it is clear that good care (even what is outlined here) will not be cheap. For a variety of reasons, respite care may not prove to be a great cost savings over residential care.[7]

Behavior is notoriously susceptible to environmental variation, making it difficult to separate the effects of intended change from other factors.

Cost issues cannot be resolved until more is known about the kind of care that is needed. But at this experimental stage, issues of cost must not be used to rule out innovative models. At present, some argue that approaches should not be tested because they are anticipated to cost too much. Promising approaches to improving the quality of life for people with dementia and their families should be tried. If they succeed, efforts should be made to reduce their cost.

Summary

In conclusion, specialized care for people with dementia is underway without a firm data base to guide the models. Nevertheless, we do know important things about how to provide good care.

With the information now becoming available, family members can identify the programs and practitioners who are basing interventions on established bodies of knowledge. But there are significant areas of dementia care in which not enough is known to lay down guidelines, however cautious. Research is urgently needed to test innovative models and begin to identify guidelines for specialized care. State and federal policy, funding sources and consumer demand must support the exploration and testing of creative ideas lest we end up with no more than half best in quality. It is important that consumers and provider organizations, whatever their personal opinion, recognize the validity of various arguments and the need to encourage innovation.

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Establishing a Restorative Nursing Program in LTC Facilities

Creative strategies involving both educative and administrative approaches may hold the key to maximizing functional performance of residents.

by Catharine A. Kopac

Given the current personnel shortages in nursing and rehabilitation, and the prospective payment systems that are affecting all health care delivery, long-term care is particularly vulnerable to the effects of staffing problems and cost-containment strategies.

This comes at a time when the number of elderly is increasing, particularly the number of frail elderly with multiple health care problems. Nurse managers are confronted with the task of providing quality care that moves beyond the "bed and body" routines to an individualized restorative focus.

Nursing's Responsibility. Restorative care for many nurses is synonymous with rehabilitation and, because of this perspective, a feeling persists that restoration is the responsibility of the physical therapist. Restorative nursing, however, is the responsibility of nursing. A physical therapist, occupational therapist or speech therapist sees a resident usually for less than one hour per day. During that time, the rehabilitation professional focuses on skilled assessment and evaluation, the establishment of protocols and the provision of skilled services.

Despite interdisciplinary care planning meetings, restorative protocols that require the support and participation of nursing personnel are rarely developed for the nursing care staff. In addition, those routine, repetitive procedures (e.g., learning to dress oneself, learning to transfer, passive and active range of motion exercises, supported ambulation, etc.) that require nursing time are often seen as less important than distributing medications, keeping residents clean and dry, and feeding them. Unfortunately, it is the repetitive, time-consuming tasks that constitute the bulk of restorative care.

Photo courtesy of J. Robe[illegible] [illegible]ickler

The following case is all too familiar: A frail, older person is admitted in an ambulatory state to a long-term care facility. During the first few days that he is in the facility the staff observe that he is weak and unsteady on his feet. Fearing that he will fall, he is instructed not to walk without assistance. He is "caught" several times attempting to ambulate independently and after several days is restrained to prevent ambulation without assistance. Within one month after admission the older resident is weaker, less able to ambulate and is more dependent than at the time of admission.

The downhill course that this scenario describes can and often does apply to other activities of daily living as well. How a long-term care facility chooses to address maximizing the functional performance of its residents is a question that often goes unanswered. Perhaps the solution lies in addressing the need from both an educative and administrative approach.

The Educative Approach. Nursing educators know that the basic elements of restorative nursing are taught during the introductory fundamental course at the beginning of a nurse's education. It is at this time that transfer techniques, range of motion and body mechanics are addressed.

Unless the nursing curriculum has a specific focus on rehabilitation, a nursing student rarely receives further instruction that would prepare him/her for restorative procedures. It should be mentioned that this is often accompanied by limited education in nursing care specific to the aged, and the majority of nurses in practice today have received their knowledge of nursing care of the aged through limited continuing education offerings.

Consequently, a nurse manager is often confronted with nursing personnel, both professional and paraprofessional, who have basic nursing skills but who have had limited instruction in care for the aged and no instruction in restorative care beyond some very basic procedures taught in a fundamentals course. Because restorative procedures do not require advanced skills or instruction, nurses often believe that they know what to do and do not need further education in restorative care. This is not true.

For example, many nurses do not understand the difference in the teaching of transfer, or the transferring of a resident who has had a "right-sided" stroke versus one who has had a "left-sided" stroke. And, a resident with Parkinson's disease who requires assistance with ambulation is approached very differently from one with a fractured hip despite the fact that both residents may be learning how to use a walker.

If restorative procedures are to become a part of the daily nursing care of a long-term care facility, then the nursing care staff (professional and paraprofessional) will have to be taught restorative procedures. Nothing is more frustrating for a rehabilitation professional than to spend several days working with a resident in an attempt to teach independent transfer only to find that the nursing staff transfers the resident or the resident is transferred inappropriately.

The Administrative Approach. Education by itself cannot create a restorative nursing care program. Such a program needs the support of a facility's administration, not only to educate the staff, but to create a system that will allow for the performance of restorative procedures. Such a system must take into account the current staffing shortages and type of procedures that make up the preponderance of restorative care. It must also address the interdisciplinary nature of restorative care because without the collaborative efforts of nursing and the rehabilitation staff, a restorative program cannot be successful.

RESTORATIVE NURSING ASSISTANT

Programs of Responsibility RNAs May Be Trained In:

- Basic Therapeutic Exercise
- Positioning and Range of Motion
- Ambulation
- Activities of Daily Living
- Application of Modalities (Hot Packs, Ice Packs, Massage)
- Support Assistance to Rehabilitation Professionals Evaluations, Tests and Complex Treatments

One approach to providing ongoing restorative care is to train nursing assistants in restorative procedures. This training is above and beyond the training mentioned earlier. In this training, one or two nursing assistants (the number depends on the size of the facility) are carefully selected by the nursing administration for a four- to six-week training period, during which the nursing assistant works directly with a physical therapist and learns specific non-skilled procedures and protocols that can be carried out at the direction of the physical therapist. The restorative nursing assistant does not need to be under the direct supervision of the rehabilitation professional but can be supervised by a nursing professional once training is complete.

The remaining nursing assistants who have been trained, but not as intensively, give nursing care that is supportive to the restorative program, for example, performing transfers correctly.

The restorative nursing assistant works with those residents who have been evaluated by a rehabilitation professional and had protocols established. When there is no need for skilled services and a resident is placed on a restorative program, he/she should be evaluated at least monthly to determine the effect of the program and whether there is a need to change the protocol.

The restorative nursing assistant (RNA) provides a natural "bridge" between nursing and the rehabilitation professionals. The RNA can be administratively responsible to nursing while being programmatically responsible to the physical therapist or the occupational therapist who determines the protocol for the patient.

This arrangement enables nursing to supervise the work of the RNA and determine if the nursing care staff is providing the support for the restorative programming. It enables the rehabilitation professionals to monitor and evaluate non-skilled restorative procedures for which they may have neither the time nor a reimbursement mechanism to provide the service. It enables nursing to have effective carry-through on restorative procedures because if a trained RNA is assigned to perform only restorative care, then those procedures which often are ignored in favor of "bed and body care" are a part of a particular individual's job description and, therefore, are more likely to be carried out.

Summary. Nurse managers in long-term care are confronted with providing quality care despite personnel shortages and decreasing monies. Creative strategies need to be used to move toward and/or maintain a nursing care focus that goes beyond "bed and body" services to one of individualized, restorative care.

One such strategy is to use both educative and administrative approaches and create a restorative nursing program. Such a program has the advantages of having educated staff, designated personnel, and administrative support to carry out procedures and protocols that make a difference in the everyday functioning of long-term care residents. **D.O.N.**

Catharine A. Kopac, R.N.C., Ph.D., is a nurse researcher and project manager with Rehab Inc. in Alexandria, Va., a rehabilitation firm that has successfully implemented restorative nursing programs in long-term care facilities in Virginia.

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Wandering behaviors of confused elderly people pose considerable management problems for institutional caregivers. Described is a specific comprehensive program that was implemented in an intermediate care facility/skilled nursing facility that resulted in a decrease in problematic wandering, an increase in patient freedom and safety, and an increase in staff skill and comfort in handling wandering behaviors. Described are the program components, problem identification, preventative programs and activities, appropriate interaction and intervention, and staff mobilization.

Key Words: Dementia, Alzheimer's disease, Behavioral management, Nursing care, Confusion

A Comprehensive Staff Approach to Problem Wandering[1]

Joanne Rader, RN, MN[2]

The wandering behavior of the cognitively impaired elderly is a frequent and serious problem for the staff of acute and long-term care facilities. One of the worst fears is that the individual may wander away from the unit or facility, become lost, and be at high risk for injury or death. Although statistics are not available on how many injuries or deaths occur as a result of confused wandering (Burnside, 1981), an informal survey of staff members from a number of long-term care facilities has revealed that at least 20% to 25% are aware of an incident which has resulted in the serious injury or death of a confused elderly person. Yet few facilities have developed an organized, comprehensive approach to this problem.

Wandering behavior has been poorly defined. Webster's (1962) dictionary presents a variety of meanings for wandering, such as to move aimlessly, to go to a place by any way that suits the fancy, to stray from home, or to go astray in mind or purpose. The wandering of confused persons often contain all these components. Snyder et al. (1978) defined wandering as a tendency to move about, either in a seemingly aimless or disoriented fashion, in pursuit of an indefinable or unobtainable goal, whereas Robb (1985) defined wandering as "moving about under one's own volition into unsafe situations while experiencing an impaired cognitive status." Characteristics of wandering include occurring without apparent regard to environmental constraints or hazards (entering into other's territory, paying no heed to traffic), having no specific destination or an inappropriate destination such as a childhood home, and occurring in individuals who have other signs of confusion such as memory loss or disorientation (Hussain, 1983). Hussain (1985) identified four types of wandering patterns: the exit seekers, the akathesiacs, the self-stimulators, and the modelers. The exit seekers are trying to leave. The reasons for leaving may be varied but their immediate goal is to go out the door. The akathesiacs are restless, aimless movers who pace or fidget, whose wandering is often secondary to prolonged use of psychotropic medications, as frequently occurs in the chronically mentally ill. The self-stimulators may go to a door and turn the knob but the purpose is to provide stimulation rather than to exit. The modelers simply follow others around. If the person they follow walks inside the building they will stay inside but if the person they follow exits, they will also.

Presented are four specific approaches which were implemented with little extra time or cost at a rural 127 bed intermediate care and skilled nursing facility and which effectively increased the safety of patients who exhibited problematic exit-seeking wandering behavior: problem identification, prevention programs and activities, appropriate interaction, and staff mobilization. No physical plant changes were required and the intervention was applicable to both integrated or segregated units. The overall goal of these approaches was to allow cognitively impaired individuals as much freedom as possible and still keep them safe.

Problem Identification

The first approach, early identification of potential wandering behavior, decreased problem incidents later on. Admission history was obtained from families or by observing the residents during the first days of their stay. If residents were physically capable of going out of an exit either by foot or wheelchair, and had some degree of cognitive impairment or a history of wandering, they were identified as potential problem wanderers. After this determination was made, the problem was listed on their problem list/care plans.

A special identification bracelet, labeled "cognitively impaired — if lost please call (phone number of facility)," along with the name of the patient and facility, was on the resident at all times. It was found to be helpful to prepare several in case the resident took them off. If taking them off continued to be a problem, then a metal bracelet with a non-removable clasp was obtained. Polaroid photographs (waist up) were taken of the residents and placed in the front of their charts along with height, weight, eye color, and any other distinguishing characteristics. A second photograph labeled with the resident's name and room location was placed in a designated place by the time clock so that staff checking in each shift were alerted to this resident as a potential wanderer. For 1 or 2 weeks following admission or problem identification, staff assigned to potential wanderers on each shift would introduce the residents to staff on other units and departments so they would also be familiar with them. Done clearly, yet with discretion, the dignity of the individual was maintained. For example, the staff person said, "This is Mr. Smith. He's new here and he may need some help getting adjusted. Please offer him assistance when needed." These individuals, who were quite physically able and appeared mentally intact, were often mistaken for visitors.

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[2] Clinical Specialist Mental Health Nursing, Benedictine Nursing Center, Mt. Angel, Oregon/Instructor, Mental Health Nursing, The Oregon Health Sciences University, Portland, OR 97362.

Another way used to distinguish individuals as potential problem wanderers was to place a red dot or small piece of red cloth between the residents' shoulder blades for a 3 to 4 week period until all staff were familiar with the residents. This alerted the staff to redirect them into the building or go with them as they wandered. Because this part of the intervention marked the residents in a distinguishing way, it could have been considered a violation of their right to privacy. Therefore, the benefits were weighed carefully against the risks. It was necessary to consult with the families and gain their permission to carry out these steps.

Prevention Programs and Activities

Estimates are that 50% to 60% of residents in nursing homes have some form of cognitive impairment. What percentage are potential problem wanderers has not yet been ascertained but it remains a significant number (Robb, 1985). Activities specifically designed to meet their needs may forestall some of this problem behavior. This group often has a short attention span, is restless, is easily distracted, has difficulty following directions, and does not do well in more traditional group activities. As a result, wanderers often spend much of their time restrained in wheelchairs or gerichairs with little or no structure or activities. This not only increases the restlessness, agitation, and confusion but also decreases their physical strength, balance, and endurance.

Studies have shown that activities specifically designed for cognitively impaired can reduce related problem behaviors such as wandering (Sawyer, 1983; Schwab et al., 1985) and increase the resident's physical and emotional well-being. Repetition, structure, and predictability in the environment are critical in order to allow these individuals to function at their maximum potential and decrease problem behaviors. Developing programs and activities that could potentially reduce wandering behaviors required additional education of staff and volunteers. It also involved restructuring some existing activities, such as bingo, from one group to two groups. A larger group for those with little or no cognitive impairment continued. A smaller, slower group, with one volunteer per two confused residents was developed. A special new program was designed called SERVE, an acronym for Self-Esteem, Relaxation, Vitality, and Exercise, which consisted of music, exercise, touch, and was designed and administered in a small group setting for an hour three times a week. The program was carried out over time by a variety of persons including the author, housekeeping staff, volunteers, and students (Schwab et al., 1985).

Administratively, the responsibility for developing and carrying out activities specifically designed for this group rested on many levels. It required that personnel be freed from other responsibilities to provide these services and make this need a priority. On the nursing level it required that staff see that providing activities and walking experiences for residents on a regular basis is not an extra, but a requirement as part of the care plan. This was done creatively in small groups so that social interaction between residents also increased and the amount of staff time required decreased. A clear sense of teamwork was required to get these programs installed. All employees in the care setting needed to see themselves as part of an overall program to ensure safety and quality of life to the confused residents.

Appropriate Interaction

The third approach, choosing skillful interactions and interventions, was based on the premise that many problem behaviors among the cognitively impaired residents, such as wandering, agitation, and combativeness, are the result of unskillful or unhelpful interactions by caregivers (Bartol, 1979; Rader et al., 1985). Much of how staff interacted with the confused resident had been the result of trial and error. In addition, staff had been told that Reality Orientation was an appropriate intervention when residents were disoriented to persons, time, place, and events (Buckholdt & Gubrium, 1983; Campos, 1984; Nodhturft & Sweeney, 1982; Zarit, 1980). Because so little research had been done and so little attention had been paid to which interventions are helpful to this group, staff have often had few guidelines and little or no formal education about how to work with the confused behaviors. This has resulted in excess disability (Brody et al., 1971; Schwab et al., 1985) for the confused resident. It is analagous to placing a blindfold on a totally deaf resident.

Staff added to residents' disability (brain damage) by interacting unskillfully, which, based on the amount of brain damage present, resulted in more problem behaviors than were necessary. By interacting in skillful, individualized ways, the "blindfolds" were removed from confused residents and they were able to function at their maximum potential. Although the residents often became calmer and more content through thoughtful interaction, they often did not become more oriented to person, place, or time.

One example observed of how staff created problems was when they told residents what they didn't want them to do. If a group is told not to think of a pink elephant, they have to first think it, then unthink it. This is a complex cognitive process. Yet staff frequently gave instructions to the confused residents such as, "Don't go outside." It was discovered to be far more effective and skillful to tell them exactly, in slow, concise, and concrete sentences what staff wanted them to do ("Stay in the building," or, "Walk over to me"). A nurse's aide told of assisting a female resident with Alzheimer's disease to bed. The resident was dressed for bed and the aide told her to, "Come hop into bed." The woman walked over to the bed, tried to hop, and then looked at the aide and said, "I can't." Residents also frequently pulled fire alarms because they say "Pull." The subtlety of the "in case of fire" is lost to them but the instruction "Pull" gets through. Therefore, staff were taught to use concrete, simple, and exact instructions if they wished the confused residents to function at their best.

On a nonverbal level, staff were educated that their attitudes and moods are contagious to the confused elderly. Because of impaired language function, residents might not understand the meaning of words staff use. They seem, however, to be acutely sensitive to the moods and attitudes of caregivers (Bartol, 1979; Burnside, 1981). At times, in attempting to dress a resident, a catastrophic reaction (Mace, 1984) occurred and resulted in the resident grabbing onto the caregiver's hair. If the caregiver responded in anger and tried to pull away, the resident's distress was likely to increase and cause him to tighten his grip. If instead, the caregiver recognized the action as a result of too many demands on the resident and also that the caregiver's mood was contagious, she chose instead to calmly place a hand on top of the resident's, told the person gently and calmly to, "Open your hand," or, "Let go of my hair." Gently stroking the resident's hand, if possible, further reduced the stress and allowed him to relax and let go.

Another helpful approach was to identify the confused resident's agenda behavior (Rader et al., 1985). Agenda behavior is the planning and behavior which the cognitively impaired clients use in an attempt to meet their felt social, emotional or physical needs at a given time. It includes the client's plan of action and the emotions or needs related to the plan of action. Commonly the staff attempted to force their own agenda or plan of action on the confused resident while ignoring the resident's agenda. This resulted in increased problem behavior. In the case of wandering behavior, it was discovered that by allowing the resident to play out his agenda of leaving the facility (accompanied by staff), a staff person decreased the frequency of their leaving or eliminated that behavior with little time expenditure. If the resident was thwarted in his attempt to leave (his agenda), however, he often continued to play this out until he was physically or chemically restrained to prevent the behavior. During this time he may have become very agitated, hostile, and combative. It took a great deal more staff time and energy to handle this behavior than it did to accompany the resident outside for perhaps 5 to 15 minutes. This approach required that the problem of the wandering resident not be assigned to one aide only. It became the responsibility of the entire staff. If and when the resident attempted to leave the building, and no one on the nursing staff was free to accompany the individual, then someone from another department (dietary, administration, housekeeping) was called upon to assist.

Another aspect of dealing with residents' problematic agenda behavior of wandering was to identify the feelings and needs that underlay the behavior. Frequently, prior to attempting to leave the building, a female resident would calmly announce to the staff that she had to go home to fix supper for spouse and children. At this point the staff was instructed to try to distract the resident by asking questions about her children, family or what kinds of things she liked to cook. Also they could compliment the resident on what a good cook, mother or wife she had been. These approaches addressed the needs of being useful and of being with familiar people. When residents were attempting to go home, often that home no longer physically existed. It appeared that they were trying to return to a state of mind rather than to a physical place. Therefore, getting the residents to talk about their family brought the family or home to them and lessened their need to go somewhere else. This approach was in stark contrast to traditional Reality Orientation (RO), that is, orienting the individual to the fact that their spouse was dead and their children were grown and far away. With selected individuals RO may be helpful, but by and large, for the chronically cognitively impaired, it appeared that if staff members oriented themselves to the residents' agenda and needs, the outcome was more helpful and resulted in a decrease in problem behaviors. One particularly poignant incident occurred with Mrs. D. This 88-year-old woman suffered from Alzheimer's disease and Parkinson's disease but was still able to walk unaccompanied for short distances with a walker. She had been a resident for 9 months and had only attempted to leave the building on one recent previous occasion. At that time the staff attempted to and did stop her, which precipitated 3 days of agitated, restless, and angry behavior. Four days later on a sunny but cold winter day she again mistook it to be summer and felt compelled to return to her apartment to visit her sister and to work in her garden. At first the staff tried to dissuade her because of the cold. Nothing that could be said would convince her, however, it was not summer. So she was accompanied outside. She was allowed to travel the direction she wished. The staff person merely followed her lead and provided safety information as needed. Several times Mrs. D. tried to convince the staff person to go inside as, "It was cold and no sense in two of us being lost." The staff member assured her that she had the time and was willing to be lost with her (not an easy thing for staff to do, but a critical point). She was becoming fatigued, chilled, and bewildered because she didn't know in which direction her home lay. On noticing this the staff member asked if she wished to go inside to warm up and rest, with the assurance that if she wished to she could return to her searching. She willingly went inside but was in an unfamiliar end of the building. As the staff member and resident were greeted by name, she turned to the staff member and asked, "Do you know these people?" Skillfully the staff member replied, "Yes, and I can take you to a place where you will recognize people and things. Would you like to go?" She responded affirmatively. At this point a real sadness was coming over her as she began to realize her disorientation. As the two walked to the end of the building near her room, she recognized some of the staff and as she approached her room said with great surprise, "There's my room." She then turned to the staff person and with great fatigue and sadness on her face asked, "What should I do now?" She was told to rest on her bed and that supper would be brought to her shortly. She said, "Thank you," and fell asleep. She had no agitation or restlessness following this episode and this exit seeking behavior did not recur for many months.

This approach was repeated many times with different staff and residents. Key points were allowing the residents to play out their plan, identifying the point at which they might be open to suggestions to change their plan and accept guidance, and identifying a way to allow them to re-enter the facility and still save face. When the residents began to be aware of their disorientation, it had a much different effect than it did when the staff was correcting them or making them angry. At this point, they were often very open to a new plan of action and welcomed suggestions that were supportive, guiding, and not corrective.

Staff Mobilization

All three areas described were designed to decrease the risk and frequency of the resident getting lost or wandering out of the facility. It was the staff's experience that, when implemented, these approaches significantly decreased the incidence of exit-seeking wandering. When the behavior did occur, however, it was necessary to have a swift, comprehensive, facility-wide method to mobilize staff to look for that individual. Wandering had been identified as a potential life-threatening event, much as fires have been. It made sense then to look to the concept of fire drill procedures to develop a protocol.

The Benedictine Nursing Center developed a procedure called "Code 10," which was loosely based on the fire procedures. The purpose was to find the resident as quickly as possible and maintain the dignity and privacy of the individual. The procedure was carried out as soon as a resident was thought to be missing from his unit. It involved all staff persons in the building. The outline of this procedure was as follows:

1. The nurse from the missing resident's unit alerted the staff by using the overhead page and saying, "Code 10. Will (missing resident's name) please return to team (name of unit resident is from)." Code 10 was a signal for all staff to listen because someone was missing. The name and unit told the staff who was missing. If they didn't know what the person looked like, they called the unit and got a description.
2. Staff on all units searched their areas thoroughly and systematically. After the area was searched and the resident was not located there, the staff used the overhead page to say, "Unit ________ all clear." Each area reported. If the resident was found, the nurse on the unit said, "Code 10, all clear." which alerted the staff they could resume their previous activities.
3. If the resident was not found inside or directly outside the building the person in charge was to immediately contact the police or fire department and give them the picture and description from the front of the chart. When and at what point the family was to be notified was to be a case-by-case decision.

The Code 10 procedure was easily implemented. Because a missing resident in the building was a frequent occurrence, there has been no need to have monthly Code 10 drills, as is done with fire drills. With this procedure considerable time and effort was saved and residents were swiftly located within the building. The incidence of outside, unaccompanied wandering greatly decreased, as has staff anxiety concerning this issue. It was never necessary to contact the police, fire department or notify families.

Summary

Particularly focused upon was the exit seeking wandering behaviors because they are often the most problematic for the staff and most dangerous for the residents. Four approaches were presented which have been found to effectively increase the safety of the patients and which required little extra time or cost. In the 3 years this program has been in effect at the Benedictine Nursing Center, the staff has experienced an increased sense of mastery and skill in dealing with confused residents. There have been fewer combative episodes and staff injuries. The standard of care now is to go with the resident, both physically and emotionally, rather than trying to present reality or resort to physical restraint. Residents have benefited by increased physical freedom, validation of their feelings, and a decrease in the use of psychotropic drugs to control behavior. Those residents who do wander are quickly located, usually while still in the building. There have been no incidents of patient injury as a result of wandering.

The confused elderly have the right to skillful and thoughtful care. They have the right to be as free from physical and chemical restraints as is humanly possible. The staff that cares for these individuals has the right to supportive policies and helpful education and information. These four approaches provide a comprehensive way to deal with the complex problems of wandering. They require a team approach and flexibility. They require staff education and commitment as well.

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WANDERING BEHAVIOR AND LONG-TERM CARE: AN ACTION GUIDE

REPORT PREPARED BY

Lucy Bossom Demitrack
Ann Ward Tourigny, Ph.D.

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Edited by: Anne Robinson, Beth Spencer and Laurie White
Contributing Authors: Thomas Bissonnette, Sue Haviland and Amy Kilbourn

Coping with the behavior problems that sometimes accompany dementing illnesses such as Alzheimer's disease can be difficult and frustrating for family and professional caregivers. This manual was written to help caregivers better understand the various causes of behaviors such as wandering, resistance, agitation and incontinence. Understanding the causes of difficult behaviors can help families or professionals learn ways to prevent or better cope with them. Problem-solving strategies for coping with eleven of the most common behavior problems are also discussed. 81 pages/November 1988/bound

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APPENDIX 2

Item 1

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December 12, 1989

Senator David Pryor
United States Senate
Special Committee On Aging
Washington, DC 20510-6400

Dear Senator Pryor:

Thank you for having provided me with the opportunity to speak before the "Untie The Elderly" Symposium. Although I do not believe that the opinions expressed at that symposium represented a consenus on the matter of restraints, I do feel that there definitely are issues that must be examined in regard to the use and misuse of restraints. Therefore, for the record I would like to submit the following case for the need for responsibility,input and options in the matter of determining proper policy and practice in the use of restraints.

Responsibility for patient safety, comfort, health and dignity is shared among caregivers, providers, advocates of restraint-free facilities, lawmakers, and manufacturers. Facilities and the professionals who run them have the responsibility -medically, ethically, and legally- to follow the very reasonable and humane requirement set forth by the Health Care Financing Adminstration which states that "The resident has the right to be free of physical restraints imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms." While limiting the possibility for abuse, this rule acknowledges that there are conditions under which these devices may be necessary. Caregivers, therefore, have the responsibility to examine all alternatives to restraints and use their professional judgments to make informed decisions as to when and in which specific cases these alternatives may be used.

Advocates of restraint-free facilities must go beyond merely calling for additional legislation -legislation that would eliminate restraints all together. They have the responsibility to provide caregivers with concrete and realistic alternatives that they can consider, evaluate, test, and compare. Providing broad, non-specific answers to important concerns about patient safety is an evasion of responsibility. Telling providers -as Untie the Elderly did in its August 1989 newsletter- that "Alternatives must be tried until something works" is a risky and unsatisfying suggestion. One way to exercise this responsibility is for Untie the Elderly to contact manufacturers of restraints and discuss with them options that may already exist, or explore the possibility of developing options that can be introduced to providers.

We manufacturers have responsibilities, too. Among them is the need to monitor the ways in which our restraints are applied. One of the most frequently used devices is the cross-over vest. It was determined that many restraint-related incidents were the result of this vest being applied with the opening to the patient's back. This was common practice because caregivers were unaware of the danger that this manner of application presents when the neckline is placed too close to the patient's neck. Therefore, as part of our instructions and educational materials, we have included warnings against this method of application. Such warnings plus the availability of proper in-service instruction will reduce restraint-related incidents.

We manufacturers have the responsibility to provide comprehensive in-service matrials to make certain that those who select and apply these devices do so correctly. Our Competence-Based In-Service Program not only provides videotaped instruction in the use of these devices, it includes a method for competence evaluation as well. The instructor's manual contains the forms for hands-on evaluation procedures that trainees must pass before they can be considered competent to apply safety devices.

Manufacturers also have the responsibility to listen to health care professionals and work with them to design alternatives to some kinds of restraints. In consultation with these professionals we have developed alternatives to restraints that can and do work for certain patients. There are several, however, space limits us to presenting only a few. These will be discussed a little later on.

An additional responsibility that we manufacturers have is to inform providers of possible misleading information that may be offered -albeit unintentionally- from organzations like Untie the Elderly. Specifically, they are telling providers that there are no known reported U.S. cases where the failure to use restraints was the basis of successful litigation, thus, providers are less likely to face law suits by not using restraints than by using them. This stands in contradiction to the experiences of insurance companies that warn that hip fracture among the elderly is a common reason for litigation, and that plaintiffs often base their allegations of malpractice on the failure to order restraints. Based on the experiences of insurance companies, Untie the Elderly should examine more closely the matter of liability based on use or nonuse of restraints before offering such advice.

Lawmakers have the responsibility of drafting and enacting the laws that will form the basis of the ways in which we will care for our elderly. To properly discharge that responsibility, it is vital that all informed points of view are solicited and considered before any decisions are made and policies formulated that would affect the range of options from which nursing care professionals may choose in determining the best and safest ways to care for their patients. Failure to establish a consensus on the issue of restraints may lead to policies that could threaten the safety of aged patients. Lawmakers -indeed, all of us- need more information about restraints. We need input.

A comprehensive review of the literature dealing with restraints appeared in the January, 1989 issue of the Journal of the American Geriatrics Society. In it the authors note that "Since 1980 the literature regarding restraint use with the elderly has increased markedly. Actual research on physical restraint is, however, sparse...." Indeed, Untie the Elderly echos this. The Small Group Notes from their August 9, 1989 planning meeting state "Very little research has been done on the issue of restraints up to this point." They go on to identify these areas for such research:

Impact on patients.
Are there some individuals who need them?
Are there some conditions that warrent their use?

The call for impartial research in this matter also comes from Dr. John Blass, the Chairman of the President's Committee on Alzheimer's Disease. His concern is that failure to look carefully into the issue of restraints as they apply to Alzheiner's patients may place them at substantial risk.

These calls for research --for more input-- are well-taken. Until that research is in and evlauated, none of us can be certain of what we need to do in order to establish a rational approach toward the use of restraints with the elderly.

Input must come from well-designed research, from facilities with diverse patient populations and staffing conditions, from risk managers, from manufacturers, and from patients and their families.

From input we can develop options. I want to speak specifically about some options that Skil-Care offers. Our company takes a minimalist position on the issue of patient safety aides. We believe in using the least restrictive device possible to meet a patient's safety need. For example, sliding out of wheelchairs is a problem one encounters among a good number of nursing home residents. For some, a wedge-shaped cushion is sufficient to prevent sliding. If, however, this is not sufficient to keep the patient properly and safely seated, a special cushion with a saddle-like pommel may be required to prevent sliding. And if this doesn't work, the patient may require a restraint-type device with a crotch pad to control sliding. We developed these options by working with caregivers whose input, suggestions, and testing evaluations were instrumental in arriving at their designs.

Many patients require no more than a simple wheelchair belt. For those who can get up and walk around unassisted, an easy-to-open belt with a Velcro-type closure is the answer. These patients can have both a sense of safety and autonomy. Other patients, though, should not walk about unassisted and this easy-to-open belt may invite injury. That's why we also offer various types of belts that tie behind the wheelchair, out of the patient's easy reach. The caregiver should have the option of selecting the appropriate belt based on his or her personal knowledge of the patient's capabilities or limitations. Is this an option we want to eliminate?

I would like to conclude my remarks by again quoting from the article in the Journal of the American Geriatrics Society. Its authors explain:

> With an increasingly frail aging population, situations where elders appear unsafe, uncooperative, or noncompliant with care become commonplace. The need, therefore, to balance autonomy, patient safety, and quality of life will be essential. A remaining challange in meeting this need for patient care is the development and testing of alternatives to physical restraints.

This is indeed a responsible statement that calls for inputs and does not limit options. We in the health care products manufacturing industry accept this as our goal.

Yours truly,
SKIL-CARE CORPORATION

Arnold Silverman
President

Item 2

UNITED STATES SENATE SPECIAL COMMITTEE ON AGING
"UNTIE THE ELDERLY: QUALITY CARE WITHOUT RESTRAINTS"

December 4, 1989

Ladies and Gentlemen: My name is Fred Watson. I serve as the Administrator of Christian City Convalescent Center, a 200-bed facility located at 7300 Lester Road, Atlanta, GA 30349. I am also here as a member of the American Health Care Association, an organization that represents almost 10,000 facilities in the country. I appreciate the opportunity to share my perspective on the subject of restraints. Hopefully, this symposium will begin to lead our nation and our society to an acceptable means of providing Quality of Life and safety in all health care facilities.

Our culture and society has not been willing to deal with this matter; so health care providers, physicians, nurses and those who pay for health care have responded in the best and most prudent means available to provide safety to the residents. Are we ready to change many years of using restraints? Is there a better way? I believe that when a better option is available, when the American public demands a better option and is willing to pay for the needed resources, we will see changes. If removing restraints or safety devices is the answer, we must have alternatives. Administrators and nurses are caught in a vice between consumer and regulatory pressures to reduce restraints, on one hand, and the surveyors and families noting the incidents of falls and injuries resulting in punitive or legal action against them. Regardless of what is reported here today, families and attorneys are prepared to sue,if safety and protective devices are not used.

About 40% of the residents in my facility have safety devices. We have discussed this subject numerous times with our resident councils and family councils. They, the residents and families, tell us they do not want these safety belts and devices removed. You will also hear many reasons why restraints are used, but I can assure you that safety is the primary reason. True, safety can be obtained without restraints, but there must be more resources and there must be an awareness from everyone concerned to take a few risks in the interest of an overall Quality of Life. There must be an acceptance of the fact that there will be more falls and injuries, but clearly, that may be within the rights of the resident to be free from restraints.

We recently had six nurses from Manchester, England, visit our facility in a nurse exchange program. They told us that you must give the resident the right to fall. They also summed up the major difference in our two countrys' philosophy on the use of restraints in two words: "culture and litigation". In England the public accepts the reality that frail residents will fall; also, there are no law suits against the nurses or the facility. These nurses all practice in facilities where there are no private and semi-private rooms. The care is delivered in 8 to 10 bed wards, large open rooms where the nurse can closely observe the residents. If a fall is about to occur, it can usually be prevented. I do not believe our American public would be willing to give up the privacy and superior accommodations provided in this country.

We in the nursing home industry believe it would be a mistake to pass legislation or mandate that no safety restraints be used. More regulations and more legislation are not needed on this subject. We already have new regulations concerning the use of restraints that will be implemented October 1, 1990. Let's try to implement what we have. This is an emotionally-charged issue and is a common practice in most facilities across the country. I do not believe it would be wise to go against the experience and judgment of these experts without having tried and proven alternatives. It is a complex problem that cannot be solved in the halls of Washington, D.C.

WHAT CAN BE DONE?

- o I believe restraints should not be used unless absolutely necessary, and when necessary, the physician, the family, the nurses, professionals and the resident should make that choice - not a regulation.
- o I believe the need for restraints should be constantly re-evaluated. Emergencies or medical situations will always occur that may warrant the use of restraints.
- o Environmental changes should be considered on new facility design, but older facilities should not be required to make such changes without adequate funding to do so.
- o New technology should continue to be explored to find alternatives to restraints. We have some at the present time, but more needs to be done.
- o We must change the public's attitude about expectations and current practices in health care facilities.
- o Better education of staff, families and the public.
- o Increased communication with families and residents about care and the use of restraints.

- Do not take the physician out of the restraint decision making. The new requirements published February 2, 1989, do not require a physician's order.
- Restraints or the use of them should not be a legal issue. The care, or lack of care, should be the issue. Take the restraint issue out of the courts.
- Finally, I have not spoken much of resources and funding, but most facilities are faced with a lack of available personnel to work in long term care. Most states only reimburse facilities for approximately 2.5 hours of care per day. This is very inadequate and I must admit, it contributes greatly to whether or not a restraint is used. If a facility has 50 residents on a wing and 20 to 25 have to be fed at meal time with only three or four personnel on duty, how can all confused or wandering residents be supervised for safety? At least a 4.0 staffing ratio is needed for a restraint-free environment. I think there is consensus that would be a minimum. This change alone would cost billions of dollars to implement, and then, only if we could find sufficient numbers of staff to fill the positions. In my state, the average rate of reimbursement is $40.00 per day - less than the cost of an inexpensive motel room. Our state cannot afford to pay for a restraint-free environment.

I have heard it said that if a nursing home cannot meet the needs of the resident without restraints, they should get out of the business. This solution may not be practical due to the ever increasing demands for more and more beds over the next decade. We have many facilities that use restraints and provide excellent care. Also, most hospitals use restraints on the same residents transferred to our facilities. What happens in that 15-minute ambulance drive to the nursing home where a restraint was acceptable in the hospital, but not acceptable in the nursing home?

Last month the Journal of the American Medical Association published a study that the typical nursing home resident over the age of 85 likely suffers from Alzheimer's disease. Many of these confused or frail elderly must be protected from falls and wandering. Without proven alternatives, the issue of safety and Quality of Life will become even more serious than it is today. We have a complex problem. Symposiums such as this will help us deal more effectively with the situation, and I encourage everyone to include the care-givers and providers in any decisions for the future.

Thank you for the opportunity to appear before you.

"UNTIE THE ELDERLY" - ADDITIONAL COMMENTS AND RECOMMENDATIONS

Fred A. Watson

December 4, 1989

Not opposed to what the Kendal Foundation is trying to accomplish. Many nursing homes are already attempting to reduce restraints.

According to HCFA data, there are already over 1,600 facilities with less than 20% use of restraints. (Average is 41%)

We just cannot one day remove all restraints. HCFA's new regulations, through the new assessment and care planning guidelines, will allow the facilities to gradually reduce and eliminate unnecessary use of restraints.

Some of us in the industry feel it will require more staffing. Even a minimum of one additional nursing hour will cost approximately 1/2 billion dollars per year.

There is more study needed. Some states have already had cases involving restraints. In Vermont, the State Supreme Court ruled as follows: "Insofar as restraints are used to enhance the safety of the home's residents, and the method used is humane, the statute does not permit their total prohibition."

In fact, HCFA has termed the use of restraints in some cases as "enablers".

A Wisconsin malpractice case dealt with a resident who fell out of a wheelchair. The patient claimed that the home was negligent for not tying him into the wheelchair. The court held the home negligent.

There is a fine line between restraints that help the patient and those that harm him.

RECOMMENDATIONS:

1. Continue awareness and public education of this issue.
2. Reduce or prohibit litigation of the issue of whether to restrain or not to restrain.
3. Delay any further regulation or legislation until after the new regulations to be implemented are in effect for at least one year to determine if positive results are obtained.
4. Conduct and fund a management pilot study encompassing a cross section of the nursing homes in the country working with consumers, providers and regulators. The purpose would be to identify:
    - o Factors to help with intervention toward restraint-free environment.
    - o What happens to levels of nursing staff and the cost of service.
    - o Study the impact of relationships with physicians and families.
    - o What implications for building design.
    - o Implication on litigation and how it affects management behavior.
    - o Attitudes toward resident autonomy.
    - o Effectiveness or ineffectiveness of restraints to prevent accidents and injuries.
    - o Identify satisfactory alternatives.
    - o Development of resident data base to document affects of restraint use.

Revised 1-15-90

Item 3

UNTIE THE ELDERLY: QUALITY CARE WITHOUT RESTRAINTS
A National Symposium Co-sponsored by the US Senate Special Committee on Aging and The Kendal Corporation

Legal Issues Involved in the Use of Restraints: Analyzing the Risks

Alan Reeve Hunt, Esquire
Montgomery, McCracken, Walker & Rhoads
3 Parkway - 20th Floor
Philadelphia, PA 19102

Health care institutions may abandon the use of physical restraints without incurring a significant risk of being sued for malpractice. There are few precedents supporting successful malpractice claims against long term care facilities based upon a failure to restrain. In fact, the striking conclusion from an examination of cases involving restraints both in nursing homes and hospitals is that the use of restraints has produced more successful law suits than non-use. Moreover, the strong trend of Federal regulations to limit use of restraints makes it even less likely that a failure to restrain will be held actionable in the future. (See particularly new Health Care Financing Administration Rules and Regulations, 54 Fed. Reg. 5363 (1989)).

Why have there been so few cases holding that injuries resulting from falls or from wandering off premises- the two most frequently cited justifications for the use of physical restraints- could and should have been prevented by the application of restraints? A primary reason is probably the lack of economic incentive to actively pursue such law suits. The amount of damages plaintiffs may anticipate recovering based upon injuries to or even upon the death of a frail elderly person without earning capacity is modest indeed.

Another reason is the difficulty of establishing a causal connection between the failure to restrain and the injury. In the few cases decided there is a clear recognition by courts of the natural propensity of the frail elderly to fall or to wander, with the implicit suggestion that accidents are, sooner or later, inevitable.

Moreover, courts in several cases have avoided a holding based on a failure to restrain and have instead found that the facility has failed to meet a reasonable standard of care which insured the safety of the patient. Some very fine line drawing is necessary. In Horton v. Niagara Falls Memorial Medical Center, 380 N.Y.S.2d 116 (N.Y. App. Div., 1976), the court attempted to draw the line:

> [W]hile the fact that the hospital staff followed the instructions of the patient's attending physician on the use of restraints may protect the hospital from liability on that issue (assuming the physician was fully informed and that the hospital had no reason to believe that the care was inadequate), it is not conclusive in matters in which the hospital has a separate and independent duty to the patient. The duty of the hospital to supervise the patient and prevent him from injuring himself remained, even after the physician's instructions were given, and the court's charge properly instructed the jury on this responsibility. Id. at 120.

In Horton, the hospital was found negligent in its duty to provide reasonable care to a patient whose capacity to care for himself was limited, not in its failure to restrain the patient.

Two Louisiana cases address the issue of the standard of care for patients known to be confused and incapable of caring for themselves. In Booty v. Kentwood Manor Nursing Home, Inc., 483 So.2d 634 (La. Ct. App., 1985) and Fields v. Senior Citizens Center, Inc, 528 So.2d 573 (La. Ct. App., 1988), nursing homes had reasonably responded to the difficulty of caring for the confused, wandering patient by installing alarm systems. In both cases, the systems were not operating at the time of the injury. Additionally, the physical layout of the buildings made it difficult to keep patients under close observation.

Although the family members in Fields were aware that individual supervision would not be provided, and in fact had signed a release, the facility was found negligent in its care of the decedent. The release was held inadmissible.

What becomes evident in these cases and in yet another Louisiana case, McGillivray v. Rapides Iberia Management Enterprises, 493 So.2d 819 (La. Ct. App., 1986), is an unwillingness on the part of the court to hold that there was a duty to restrain. Rather, the court emphasizes the duty to supervise and provide reasonable care. If the facility could have met this standard by a properly operating alarm system or by proper supervision, then negligence lies in the improper performance of those duties, not in the failure to restrain. *McGillivray* emphasizes this distinction in italics: "*The findings below refer not to the failure of nurses to place Mr. Fox in the harness that night, but to their failure to guard against his leaving the premises.*" *McGillivray* 493 So.2d at 823.

The new HCFA regulations on the use of restraints powerfully reinforce the hesitancy of some courts to base decisions on a failure to restrain. Regulations narrowing the area in which restraints are permissible create an environment in which it is difficult to demonstrate that physical restraints are the norm and that their use constitutes accepted good practice. The regulations issued by HCFA in February, 1989 (mentioned *supra*) say:

> The resident has the right to be free from any physical restraints imposed...for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.[1]

The Interpretive Guidelines (which provide guidance to surveyors) focus on an analysis of the reason for the use of the restraint: discipline and convenience or as an enabler to assist the resident in attaining and maintaining "the resident's highest practicable physical, mental or psycho-social well-being." Interpretive Guidelines - Skilled Nursing Facilities and Intermediate Care Facilities, at P-52. Less restrictive measures must be considered prior to using physical restraints and the facility must have evidence of consulting with health care professionals regarding this use.

The Guidelines do not allow the decision to use physical restraints to be made unilaterally by the facility. The use must first be explained to the resident, family member or legal representative. If the resident, family member or legal representative agrees to the use (and this should be documented), the restraint may only be used "for the specific period for which the restraint has been determined to be an enabler." *Id.*, at P-51.

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[1] Although the regulations do not mention physician approval of the use of restraints, the Omnibus Budget Reconciliation Act of 1987 includes a requirement that restraints be used only to insure the physical safety of the resident and only upon the written order of a physician specifying "the duration and circumstances under which the restraints are to be used." Thus while a physician's order continues to be essential to the proper use of a restraint, it is plainly not conclusive if other standards for proper use are not met.

Where restraints are used, the emphasis in the Guidelines is on the use of restraints as a therapeutic part of a comprehensive care plan and on the documentation of the need for restraints and re-evaluation of that need.

Where nursing homes have been found liable in cases where restraints were used, the liability has been founded on lack of supervision or inadequate or inappropriate use of the restraint.

In Dusine v. Golden Shares Convalescent Center, Inc., 249 So. 2d 4 (Fla. App. 1971), a patient was injured when left unattended in a vest restraint. Lack of supervision, rather than misuse of a restraint, was the pivotal factor in finding the nursing home liable since regulations required extensive supervision of a patient on restraints. See also Golden Villa Nursing Home, Inc. v. Smith, 674 S.W. 2d 343 (Tex. App. 1984) (failure to supervise a patient known to wander).

Misuse of a restraint and failure to obtain physician approval for its use was the basis of nursing home liability in Fleming v. Prince George's County, 277 Md. 655, 358 A.2d 892 (1976). Nurses applied an inadequate restraint without physician approval. The patient, driven by a "psychotic" desire, escaped from the restraint and suffered a fatal fall. See also Dow v. State, 50 N.Y. 2d 342, 183 Misc. 674 (1944) (inadequate restraint of a manic-depressive patient); Morningside Hospital and Training School for Nurses v. Pennington, 189 Okla. 170, 114 P.2d 943 (1941) (hospital found negligent in the type of restraint applied) and Northrup v. Archbishop Bergan Mercy Hospital, 575 F.2d 605 (1978) (failure to adequately restrain, secure and supervise patient).

A recent Alabama Circuit Court decision (unreported) held a nursing home liable for the death of an eighty-six year old woman. A "safety vest" was applied backwards, and the decedent slid down in her chair and strangled. The trial court awarded the plaintiff 2.5 million dollars in damages against the owner of the facility, but dismissed the complaint as to the manufacturer of the restraint. Motions for a new trial were denied and the case is on appeal. Ruby Davis as Executor of the Estate of Ruby Pearl Pettus v. Montrose Bay Care Center, Vari-Care, Inc. and the J. T. Posey Company. (June 19, 1989.)

An exception to the prevailing trend of the decisions is Kujawski v. Arborview Health Care Center, 139 Wis. 2d. 455, 407 N.W. 2d. 249 (1987) a decision in which the Wisconsin Supreme Court held that the jury could determine without expert testimony whether restraints should have been used. While the decision was not a verdict for the plaintiff, but rather a determination that there should be a new trial, the case was settled before the second trial. The settlement figure is not available but it's fair to guess that the settlement amounted in practical effect to a plaintiff's victory.

In an unpublished U.S. District Court opinion in 1987, a government hospital was found negligent for failing to restrain a patient known by the staff to eat inappropriate objects. The patient choked to death on toilet paper and paper towels. Expert testimony was used to convince the judge that use of restraints is standard practice in the care of such patients. In light of the HCFA restraint regulations and Interpretive Guidelines, it is doubtful that the use of a restraint as standard practice would be upheld today.

Health care institutions will not be entirely comforted by the assurance that they- or their insurance carriers- are likely to win any malpractice suits brought against them for alleged failure to restrain. What matters most, from the stand-point of institutional morale and public image, is that law suits against the institution not be brought at all.

Institutions which have abandoned the use of physical restraints, or which have never used them at all, do not report- and this is wholly anecdotal, based on asking the question to a number of audiences of health care administrators- that claims have been made. They strongly advise, however, that the risk of suit may be greatly lessened by:

1. Making clear to patients and to their families from the outset that the institutional policy is non-restraint; people who are uncomfortable with this must be encouraged to look elsewhere.

2. Bringing the patient's family or others charged with protecting his or her welfare into developing care plans for the patient which specifically negate the use of restraints.

3. Bringing the attending physician into cooperation with care plans.

4. Maintaining extra and unremitting vigilance to keep the premises free of hazards.

5. Using alternatives to restraints such as buzzer or other warning systems, or removable ribbons which encourage a patient not to leave his or her room unattended, and so forth.

Item 4

PRESENTATION OF MARSHALL B. KAPP, J.D.,M.P.H.

Professor, Department of Community Health
Director, Office of Geriatric Medicine and Gerontology
Wright State University School of Medicine
Dayton, Ohio
Telephone 513-873-3313

"Legal Liability Issues"

December 4, 1989

Hearing of U.S. Senate Special Aging Committee on
The Use of Physical Restraints in Nursing Homes

At the recent meeting of the Gerontological Society of America, I conducted a poster presentation on the prevalence of legal risk management systems--defined as organized internal approaches to the identification, prevention, and mitigation of incidents that might lead to potential legal claims--in American nursing homes. During the course of ninety minutes, four separate individuals, independent of each other, approached me and asked if, by risk management, I was referring to such practices as physically restraining nursing home residents so that they do not fall down, injure themselves, and bring lawsuits against the facility.

Apprehension of legal liability is frequently used as a pretext for actions actually based on professional bias, staff convenience, and behavior control. Physical restraints have been used historically in this country long before the litigation explosion of the past quarter century and invention of the concept of "defensive medicine". Nonetheless, there is little doubt that--to a significant extent--a sincere fear of liability, or at least of litigation, fuels the widespread practice of physically restraining residents in nursing homes in the United States today.[1] Regrettably, some short-sighted legal commentators and risk managers exacerbate this anxiety.[2] As Carter Williams has urged in an editorial in The Gerontologist,[3] "The legal noose now thought to be around the necks of the nurse, physician, and nursing home administrator who do not restrain every resident who falls or may fall, must be exposed for the myth it is."

In my brief time today, I propose to take up this challenge by: first, placing the legal risks associated with non-restraint of residents into some realistic perspective; second, suggesting risk management strategies for providers to reduce these risks even further; and third, suggesting some public policy options for overcoming the legal paranoia that too often dictates the improper and deleterious use of physical restraints in American nursing homes.

PUTTING LEGAL RISKS INTO PERSPECTIVE

Although their number has been relatively small in terms of overall health care malpractice litigation, there indeed have been some lawsuits in which nursing homes and their personnel have been held legally responsible for injuries incurred by non-restrained residents. This fact does not by any means, however, support the notion that widespread, indiscriminate, routine use of physical restraints is a prudent, effective form of defensive medicine or risk management for providers.

First, no lawsuit has yet been successful against a facility *solely* for failure to restrain a resident.[4] Prevailing plaintiffs have had to prove by a preponderance of evidence other elements of negligence, such as improper assessment of the resident, a failure to monitor the resident appropriately, inadequate documentation concerning resident care,[5] or failure to respond to the fall in a timely and professionally acceptable manner.

Further, any legal exposure associated with failure to restrain residents is substantially outweighed by the legal risks attached to the improper application of physical restraints. Mounting data show that physical restraints used in the name of defensive medicine may not only fail to be defensive, but may actually be counterproductive. Studies[6] demonstrate that the chance of morbid outcomes, including injurious falls, increases with the prolonged use of mechanical restraints, and bad outcomes--especially when they are unexpected by the resident or family--are the most reliable predictor of lawsuit initiation. Additionally, contrary to prevailing health provider wisdom as espoused in physician lounges and administrator cocktail parties, the rate of serious injury falls do not increase significantly in the absence of restraints.[7]

In quantitative terms, cases holding providers liable in the absence of nursing home restraints are far eclipsed by legal judgments imposed and settlements made on the basis of inappropriate ordering of restraints, failure to monitor and correct their adverse effects on the resident, or errors in the mechanical application of the restraint (such as in cases where the resident chokes to death on a vest that has been put on her backwards). Claims have been filed on both negligence and battery theories. Thus, the rational health care provider, if guided solely by legal self-interest rather than resident welfare, ought to opt more often for withholding rather than imposing restraints.

Even more important, regulatory sanctions such as delicensure and decertification from the Medicaid and Medicare programs, which are a much greater concern for nursing homes than possible tort liability, are substantially more likely for imposing rather than withholding physical restraints. Both federal and state statutes and regulations, especially under OBRA 87 and implementing regulations and survey procedures, clearly and intentionally tilt the regulatory odds against the provider who indiscriminately applies physical restraints to its residents.

RISK MANAGEMENT THROUGH RESIDENT ASSUMPTION OF RISK

Even the relatively limited legal risk associated with non-restraint of residents may be reduced in many situations by shifting it to the resident or the resident's substitute decisionmaker. In the lawsuits that have been filed in which injury occurred to an unrestrained resident, there is scant evidence that, as a matter of basic informed consent, anyone communicated adequately with the resident or substitute decisionmaker concerning the benefits of proposed restraints, the reasonable alternatives,[8] and the potential adverse consequences of foregoing recommended restraints.

In other health care contexts, the courts have recognized the doctrine of assumption of risk as a complete defense to a negligence action, where the patient voluntarily and knowingly (i.e., after being adequately informed by the provider) refused to comply or cooperate with the provider's recommendation and agreed to accept responsibility for foreseeable adverse consequences of that decision.[9] Some courts have alternatively or additionally permitted such a defense by characterizing the patient's conduct as contributory or comparative negligence.[10]

These defenses should be fully applicable to physical restraint situations where the resident or surrogate is informed of the potential risks, understands them, and voluntarily accepts the consequences.[11] We permit individuals to take risks in all other aspects of everyday life, including the medical decisionmaking realm--such as permitting AIDS patients to experiment with medications of unproven safety or efficacy and carrying potential tremendous side effects. There is no reason to restrict the choice of nursing home residents or those acting in their best interests from knowingly and voluntarily accepting specific, limited risks of injury in exchange for a modicum of freedom and dignity, particularly where alternative strategies and technologies exist to accomplish the same legitimate goals as restraints with much less restriction or intrusion.

In addition, from a psychological perspective, residents and substitute decisionmakers who share in the decisionmaking process are less apt to try to shift the blame to someone else in the event of a maloccurrence.[12]

Although the mental incapacity of many nursing home residents may make rational conversation and decisionmaking on their part infeasible,[13] the law's formal recognition of the authority of appropriate substitute decisionmakers is growing.[14] Unless a substitute is acting in clear disregard of a resident's best interests or personal values and preferences, the substitute should be able to choose non-restraint on the resident's behalf, accept the accompanying risks, and thereby relieve the nursing home of potential liability. It has even been suggested that we experiment with the use of advance directives (analogous to Living Wills and Durable Powers of Attorney) to allow presently capable individuals to express and document their preferences concerning the use of physical restraints in the future eventuality that they become decisionally incapacitated and placed in a nursing home.[15]

PUBLIC POLICY OPTIONS

In the context of examining the practices of a state hospital for the mentally retarded, the United States Supreme Court observed in 1982 that "***an institution cannot protect its residents from all danger of violence if it is to permit them to have any freedom of movement."[16] The same observation holds even truer in the nursing home arena. Several policy options should be considered in an attempt to strike a good balance between the facility's right and duty to protect residents, on one hand, and the resident's freedom, on the other.

First, states (with federal encouragement) should umambigously enunciate the applicability of the assumption of risk doctrine to the nursing home physical restraint context, assuming that risks are understood and accepted by or for the resident in a voluntary, competent, and informed fashion and that proper documentation is present. Failure to do this obviously discourages shared decisionmaking. One can hardly expect or require that providers permit residents or their surrogates to make their own decisions, on one hand, and on the other to hold those providers legally responsible for a poor outcome which results from a choice made by or for the resident. Unequivocal enunciation of the assumption of risk doctrine carries strong benefits for residents, providers, and society.[17]

Second, courts and legislatures must clearly recognize and enforce standards of medical practice that are based on scientific evidence rather than industry custom or fashion. As the data cited previously shows, this would mean a legal standard favoring non-restraint rather than the current deference toward industry habit.[18] Published provider standards[19] and actually behavior could be expected to follow the legal incentives.

Third, since perception of the law is a more important determinant of behavior than is reality, a large-scale educational campaign is needed to convince providers that a more judicious and discriminating use of physical restraints is sensible legal prophylaxis as well as good clinical practice and promoting of resident dignity and autonomy. This campaign should include publications, continuing education programs, and joint efforts with trade and professional organizations. Government has a role in financing, sponsoring, and promoting such efforts.

Finally, providers must be convinced that their relative risks for indiscriminate, inappropriate use of physical restraints places them at much greater liability and regulatory risk than does less reliance on restraints as a first strategy for resident control. Courts must be sympathetic to plaintiff claims of improper restraint and legislatures and administrative agencies must continue to limit the permissible circumstances for restraint use and vigorously enforce stringent health and safety requirements regarding their imposition, monitoring, continuation, and documentation.

Ideally, the nursing home industry is educable on the issues under discussion at today's hearing. To the extent that education, persuasion, and voluntary incentives do not work, let us as a society at least bludgeon the industry in the proper direction.

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9. See, e.g., Shorter v. Drury, 103 Wash.2d 645, 695 P.2d 116 (1985) (patient assumed the risk of death where the physician perforated the uterus causing hemorrhaging but the patient before

surgery refused a transfusion); *Haynes* v. *Hoffman*, 164 Ga. App. 236, 296 S.E.2d 216 (1982) (patient's failure to disclose medical history that he knows is material constitutes assumption of risk); *Steele* v. *Woods*, 327 S.W.2d 187, 196 (Mo. 1959)(patient's refusal of physician's recommendation is assumption of risk); *Mainfort* v. *Giannestras*, 49 Ohio Ap. 440, 111 N.E.2d 692 (Ohio Ct. App. 1951) (patient refusal of physician's recommendation is assumption of risk). See also *Routt* v. *Ready*, 265 F. 455, 456 (D.C.Cir. 1920).

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11. See W. Prosser & W. Keeton, THE LAW OF TORTS (West Publishing Company: St. Paul, MN) at 190-191 (5th Ed. 1984).

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Item 5

Freedom from restraint: consequences of reducing physical restraints in the management of the elderly

Colin Powell, MB, FRCP (Edin)
Lynne Mitchell-Pedersen, RN, MEd
Elliot Fingerote, BSc (Pharm), MSc
Lois Edmund, PhD

Physical restraint is commonly used in the management of elderly people in North American hospitals and nursing homes. Between December 1981 and March 1982 the Department of Geriatric Medicine, St. Boniface General Hospital, Winnipeg, changed its practice regarding the use of such restraints. In the fiscal year 1980–81 the rate of application of physical restraints was 52 per 1000 patient-days and the frequency of falls 7 per 1000 patient-days. By 1986–87 the figures were 0.3 and 8.7 per 1000 patient-days respectively; the increase in falls was not clinically significant. During the study period there was a 40% reduction in the use of chemical restraints (psychotropic drugs other than hypnotic and antidepressant agents). Here we record how this change in practice occurred and persisted.

Dans les hôpitaux et hospices nord-américains on a souvent recours à des moyens physiques de contention dans le soin des personnes âgées. Ces moyens ont fait, de décembre 1981 à mars 1982, l'objet d'une réforme dans le service de gériatrie de l'Hôpital général de St-Boniface, à Winnipeg. Exprimés par 1000 jours-patients, les taux de contention et de chutes qui, dans l'année fiscale 1980–81 étaient respectivement de 52 et de 7, passent en 1986–87 à 0,3 et 8,7; l'augmentation du taux de chutes n'est pas statistiquement significatif. Dans le même temps on a vu diminuer de 40% l'emploi des moyens chimiques de contention, soit les psychotropes autres que les hypnotiques et les antidépresseurs. On décrit ici comment ces changements sont intervenus et demeurent dans notre pratique.

From the Department of Geriatric Medicine, St. Boniface General Hospital, Winnipeg

Reprint requests to: Dr. Colin Powell, Department of Geriatric Medicine, St. Boniface General Hospital, 409 Tache Ave., Winnipeg, Man. R2H 2A6

Newcomers to North American geriatric practice are often confronted by the dramatic sight of elderly people in hospitals and nursing homes physically restrained by means of jackets, wristlets or bands of various designs.[1-3] Such practice has received comment but little analysis.[4,5]

After a tragic accident in which a patient strangled to death because of an improperly applied restraint jacket the Department of Geriatric Medicine at St. Boniface General Hospital, Winnipeg, decided to analyse the reasons for restraint use and to examine alternatives. Recognizing that there were insuperable barriers to random allocation of patients we had planned to measure the use of restraints and then to stop their use to do before-and-after and between-ward analyses of the effects of removing restraints on the number of falls. However, when the time came to implement the experiment we found that the use of physical restraints had virtually ceased throughout the department; therefore, we had to collect data retrospectively; the study period comprised the fiscal years from 1980–81 to 1986–87.

Methods

Practice setting

The inpatient component of the Department of Geriatric Medicine comprises 160 beds in an 850-bed general teaching hospital. The department admits acutely ill patients who do not need critical care or surgery. Elderly patients who require rehabilitation are transferred from other departments and other hospitals. There are special programs for patients in postoperative rehabilitation from orthopedic injuries, for amputees and for stroke victims.

Restraints

A mechanical restraint is a device used to inhibit free physical movement.[6] We included limb restraints, mitts, wristlets, anklets, jackets and wheelchair restraints. We excluded bedrails, geriatric chairs and mechanical aids intended to enhance a patient's independence and safe mobility (e.g., the wheelchair lap belt for patients who have had a double above-knee amputation). The Central Supply Department supplied restraints as ordered and recorded these requests (by type of restraint) by fiscal year. We confirmed the reasonable assumption that the issuing of a restraint resulted in its use. Restraints were returned to the supply department for laundering after each use.

A chemical restraint is a drug used to inhibit a particular behaviour or movement.[4] We identified the use of psychotropic drugs other than hypnotic or antidepressant agents from drug consumption reports produced by the pharmacy department during the study period. The agents most commonly prescribed were chlorpromazine, diazepam, haloperidol and thioridazine. Hydroxyzine, an antihistamine with marked sedative properties, was also included because of its frequent use on one ward. Other drugs, prescribed in relatively small amounts, were alprazolam, flupenthixol, fluphenazine, lorazepam, methotrimeprazine, oxazepam, perphenazine and trifluoperazine.

Falls

From the nursing records we obtained the incident reports of all falls that occurred during the study period and classified them as being serious or nonserious. Serious falls were those in which a physician had to do more than just examine the patient; treatment varied from simple suturing to orthopedic surgery. Nonserious falls were those for which no treatment or only first aid was required.

Policy discussion

From November 1981 to January 1982 the department's policy and practices concerning restraints was reviewed by its advisory committee — a group of 18 people comprising the managers of all services offered in the department (e.g., nursing, rehabilitation therapy and social work) and full-time medical staff. Problems facing the patients, their families, the staff and the hospital were identified.

- Patients who were physically restrained often either were passive and withdrawn or protested, were agitated and exhibited increasingly disruptive behaviour. They were more likely than unrestrained patients to be regarded as unsafe, disturbed, dangerous or incompetent; their self-perception underwent similar adverse changes. Restrained patients were also faced with the problem of accidents caused by attempts to free themselves.
- A common first reaction of family members on seeing the patient physically restrained was one of distress amounting almost to horror and of profound sadness. They then would accept that "the professional knew best" and that safety was paramount. Occasionally family members, distressed by the disturbing behaviour of another patient, asked that restraints be applied.
- In taking care of patients health care professionals assume responsibility for maintaining their safety and for encouraging them to regain their independence. The tension between ensuring patient safety and encouraging patient autonomy could result in considerable anxiety, often heightened by the fear of being blamed in the event an unrestrained patient had an accident.
- The hospital was rightly concerned about its reputation as a provider of efficient and humane care. Surprisingly, the following criteria for the application of restraints were included in its policies: vagueness about time and place, restlessness and anxiety, agitation and hostility resulting from illness or surgery, toxic effects of alcohol and drugs, and the degenerative characteristics of aging. The hospital's lawyer confirmed that there had never been a prosecution in Canada for the nonuse of restraints, only for their misuse. He reported that US courts have found hospitals to be at fault for not providing restraints when medically ordered. In addition, he stated that the use of restraints without a patient's consent constitutes assault, leaving the institution liable for false imprisonment.

The advisory committee then examined the management of four patient stereotypes for whom restraints were used (the wandering mentally impaired person, the unsafely mobile person, one who interferes with life support and the physically aggressive person) as well as feasible alternatives. Thorough assessment of patients, their environment and their caregivers by the rehabilitation team was deemed essential, specific attention to be paid to the patient's behaviour before the illness, the current behavioural problem and the consequences of this behaviour. The committee also discussed alternative solutions for managing each stereotype to produce departmental policies and guidelines for the use of restraints.

The above information and discussion were made known informally by members of the advisory committee to their respective disciplines represented in the department. A videotape of interviews with patients, relatives and staff (including the hospital lawyer) provided a valuable teaching aid for the rest of the hospital and produced remarkable agreement within the department about the limited role of physical restraints.

Results

Table I shows the decreased use of restraints by the end of the study period. During this time there was no change in the number of nursing staff or other staff. Table II shows the numbers of serious and nonserious falls. There were no statistically significant differences in the ratio of serious falls to total falls between any 2 years; that is, serious falls were not occurring more frequently than nonserious falls.

There was no evidence that chemical restraints were substituted for physical restraints. The use of psychotropic drugs decreased by 29.5% between 1980–81 and 1982–83 (the period during which the use of physical restraints declined). By the end of the study period a further decline of 22.1% was recorded, particularly in the use of chlorpromazine, hydroxyzine and thioridazine. The rate of administration decreased from 1773 units per 1000 patient-days in 1980–81 to 859 units per 1000 patient-days in 1986–87, an overall reduction of 40%.

Discussion

Although this study lacked the rigour of a randomized controlled trial we believe it showed that a substantial reduction in the use of physical restraints in the care of elderly patients can be effected without consequent use of chemical restraints and untoward physical injury.

We did not begin this exercise with a theoretical framework within which we planned to effect change in behaviour. Thus, we can only seek to explain this phenomenon in retrospect. Jones[7] cogently described the use of staff discussions to effect dramatic changes in the management of patients in a mental hospital. He identified factors that would produce a creative environment: effective communication channels, problem-solving as a group, positive social learning and adoption of more flexible structures in favour of established ones. Knowles' suggested process for optimal adult learning seems to fit our experience:[8] provision of a conducive climate, participative planning, acknowledgement of needs, statement of objectives, planning of action, execution of plan and evaluation.

Table I — Use of restraints per 1000 patient-days at St. Boniface General Hospital, Winnipeg

Fiscal year	Department; no. of cases	
	Geriatric medicine	Other
1980–81	52	48
1981–82*	33	29
1982–83	2	11
1983–84	1.5	12
1984–85	1	10
1985–86	0.5	†
1986–87	0.3	†

*Change in practice occurred in late 1981.

†Data not available.

Falls are a notorious problem in hospitals. A major reason for the use of physical restraints in nonpsychiatric wards has been to prevent falls; hence decreasing the use of such restraints must be carefully studied. Wieman and Obear,[9] having studied falls and restraint use in a New York nursing facility, concluded that "restraint use is a poor measure for the prevention of falls". We have no evidence that restraints prevent falls or that their removal causes them. Tinetti,[10] in a study of falls producing serious injury in ambulatory nursing home residents, found that physically restrained patients still fell. Of course, diminution in the use of restraints reduces those falls and injuries associated with restraints.[11]

It is well recognized that patients seeking to escape from restraints can suffer injury, including death from strangling.[12] Some authors have suggested that these events are underreported.[13] Curiously, none of them have recommended that restraints be removed to prevent injury. In a recent review of the literature Evans and Strumpf[14] found no evidence that the use of restraints safeguarded against injuries.

Rubenstein and associates[15] concluded that there is little evidence to support the routine use of bedrails. They contrasted British practice, in which bedrails are not routinely used, with North American practice and suggested that it reflected different attitudes toward the elderly with respect to protection versus independence. An editorial in the *Lancet* expressed some ill-disguised horror at the widespread use of bedrails and stated that "good practice requires that they should not be routinely used and their use should be continually reviewed".[16] A recent British publication carefully helps nurses in both hospitals and the community explore alternatives to physical and chemical restraints.[17] By the end of our study period geriatric chairs had all but disappeared from the department. Unfortunately, bedrails are still being used, as it is impossible to obtain high-low beds that allow patients to place their feet firmly on the ground when sitting on the edge of the bed.

Physical restraints are most commonly used among prisoners and children. Their use among the elderly may suggest to the patients that they

Table II — Number of falls, serious falls and patient-days per fiscal year in Department of Geriatric Medicine

Fiscal year	No. of falls	No. of serious falls	No. of patient-days	No. of serious falls per 1000 patient-days
1980–81	348	8	47 849	0.17
1981–82	461	8	51 371	0.16
1982–83	625	14	50 158	0.28
1983–84	603	8	47 547	0.17
1984–85	536	7	55 448	0.13
1985–86	389	9	55 088	0.16
1986–87	475	11	54 466	0.20

are being punished or perceived as childlike; it epitomizes the moral dilemma between professional paternalism and patient autonomy.[18] Deprivation of civil liberties may be as serious a matter as imposed protection against real or anticipated threats to personal safety.

An essential criterion for the use of restraints must be the jeopardized safety of a patient or others. We believe that the use of physical or chemical restraints is an unusual response to an abnormal situation and should be chosen only as a last resort. The least restrictive measure that is effective should then be used together with thorough assessment, appropriate application, rigorous documentation, and regular observation and evaluation.

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Item 6

Therapeutic activity and health status

Joan C. Rogers, PhD, OTR
Professor of Occupational Therapy
Assistant Professor of Psychiatry
Occupational Therapy Program Director
Geriatric Psychiatry and Behavioral
Neurology Module
Western Psychiatric Institute and Clinic
University of Pittsburgh
Pittsburgh, Pennsylvania

ACTIVITY has been a key, albeit controversial, concept in the development of theories of adaptation in later life. In one of the earliest formulations, disengagement theory, the elderly and society gradually disengage from each other to the satisfaction and benefit of both.[1] This mutual withdrawal results in an overall decrease in social involvement for the elderly. Activity theory was put forth in opposition to disengagement theory and posits that the path to successful aging lies in staying active and in maintaining participation patterns characteristic of middle age.[2]

Health status plays a pivotal role in both disengagement and activity theories. In disengagement theory, older adults are viewed as withdrawing from activities because they realize that they can no longer keep pace due to declining capabilities. Withdrawal allows them to protect themselves from failure and rejection. In activity theory, however, continued activity is seen as a mechanism for maintaining health. Furthermore, as health status

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begins to restrict engagement, substitute activities are to be found for those that are relinquished so that optimal health can be maintained. While both theories view health as influencing activity, only activity theory stresses activity as influencing health.

The view of health and activity as interdependent phenomena is compatible with the therapeutic application of activity. This article clarifies the health–activity linkage by exploring five basic philosophic approaches to the therapeutic use of activity with the impaired and at-risk elder. The conceptualization of order, disorder, and control for each approach is presented. Order is the healthy state that the activity specialist seeks to establish, restore, maintain, or enhance. Disorder is the unhealthy condition that is to be removed, alleviated, or prevented. Control is the way in which activity is used to achieve therapeutic goals, such as maintaining order, converting disorder to order, or preventing disorder.[3]

Therapeutic activity programming for the elder is provided by a wide variety of activity specialists with different educational backgrounds and activity skills. By examining several fundamental orientations to activity that shape the direction of care, professionals can gain insight into the various ways in which activity can be therapeutic and into the linkage between health and activity in older adults.

SELECTED THERAPEUTIC APPROACHES

Holistic

In the holistic approach to therapeutic activity, activity is engaged in for the sake of activity. Activity is preferred to passivity; it promotes a sense of overall well-being and results in a feeling of dignity, usefulness, and satisfaction, and purpose and enjoyment in living. Activity offers the opportunity for maintaining bodily integrity, sharpening mental acuity, relating to others, and contributing to the community. Activity promotes a high level of functioning in physical, cognitive, social, and spiritual domains.[4] The ordered, or healthy, state is marked by activity and involvement.

While activity is beneficial, inactivity is harmful. Inactivity spirals a host of negative symptoms that are collectively referred to as the disuse syndrome.[5] At the physical level inactivity places one at risk for problems such as decubitus ulcers, backache, osteoporosis, contractures, loss of appetite, constipation, renal stones, urinary tract infection, muscular weakness, cardiovascular deconditioning, thrombus formation, orthostatic hypotension, and pneumonia. At the psychologic level, dependency, disorientation, decreased motivation, and confusion have been traced to inactivity. Inactivity and idleness define the disordered or unhealthy state. These deleterious effects of inactivity are preventable through activity, and many are also reversible through activity.[6] Aging individuals are particularly at risk for inactivity due to age-related and disease-associated changes in physical and mental processes, which render them less mobile.

In the holistic approach, the therapeutic potential of activity lies in the *total* experience of the activity. Inactivity (disorder) is controlled through planned engagement in activity and is converted to activity (order). While involvement at some level is essential, the activity itself may be any activity. In other words, the activity is neither dependent on a particular kind of activity, such as a game, craft, or homemaking task, nor on specific activity attributes, such as visuospatial requirements or social components. There is no need to match activities with specific symptoms, diagnoses, or personal preferences. Although a person's interest in an activity may heighten engagement, the overriding consideration is getting the person active. Activity is experienced as a whole and appeals to the wholeness of the person.

Activity elicits healthy behaviors by exerting a normalizing, reality-orienting influence on the patient. Its curative properties lie in evoking action, which is the essential component of change, and in rekindling the will to live. Hence it combats the demoralization and idleness that often accompany incapacitation.[7]

Activity programming conducted from a holistic perspective is basically that of environmental engineering to provide opportunities for action and achievement.

Activity programming conducted from a holistic perspective is basically that of environmental engineering. The activity specialist's major role is to provide opportunities for action and achievement. Activity is generally delivered using a group format, and activity selection is guided by several principles.

One principle of activity selection is group programming based on common activity preferences, which are identified through interest surveys. Activity programs are then designed to emphasize the interests of the majority with lesser attention given to the concerns of the minority. A second principle is derived from assumptions about human nature, such as a need for physical exercise, for social stimulation, or for artistic expression. Such assumptions about human needs serve as the guide for activity selection and bypass individualized interest assessment. A third principle addresses the performance capabilities of group members. Recognizing that patients have various capacities to respond to activity based on, for example, their physical, mental, or social capabilities, the professional plans separate activities for "higher" and "lower" functioning patients. High and low functioning is relative to a particular group. Hence a high-functioning patient in one physical activities group might be a low-functioning patient in another.

Controversy exists regarding obligatory or voluntary attendance at group activity programs. One perspective argues that if activity programming is based on activity preferences, or is designed to meet fundamental activity requirements, or is varied according to capability, patients will be self-motivated to participate. Group norms may operate to encourage participation and to assist in overcoming inertia, anxiety, or fear. The opposite perspective argues that some patients are too sick to attend of their own volition, and since activity promotes health to a greater extent than a lack of activity, they should be coerced into attending.

Impairment

The impairment approach to therapeutic activity contrasts sharply with the holistic orientation. In this approach, specific activities are seen as remediating or preventing specific impairments. Activity, rather than being participated in for its own sake, becomes a means to an end; it is used explicitly to achieve discrete, measurable goals, and its value depends on how well it meets those goals.[8]

An impairment (disorder) is a loss or abnormality of physical or psychologic structures or functions. Examples of physical impairments associated with geriatric rehabilitation are loss of muscle strength, restrictions in joint range of motion (ROM), impaired sensation, and reduced endurance. Examples of psychologic impairments are visual–perceptual deficits, inability to problem solve, loss of memory, and impaired motivation. Impairment may be caused by disease, trauma, age-related decrements, or sensory deprivation. Activity is seen as a means of correcting or, at minimum, alleviating impairment and hence returning the patient to an impairment-free state (order).

In contrast to the generalized approach to activity in the holistic perspective, activity in this orientation is selected to focus on a discrete problem. For instance, an older person may have lost skilled use of the dominant hand due to a stroke that impaired motor control. By using the hand, the individual may regain the manual skill necessary for self-care and leisure activities. To assist the recovery process, however, the activity must be sufficiently repetitive to foster the relearning of motor control. It must also be capable of gradation. This means that as manual control improves, the activity must be made more difficult in terms of its requirements for precision, strength, and grasp patterns to elicit further improvement. Not all activities would meet these criteria.

The use of activity for psychologic impairments is similar to that for physical impairments. For example, a patient may have a perceptual deficit that is manifested as an inability to interpret depth. Because of this deficit, the patient may perceive steps as a flat walking surface and may have difficulty ascertaining if one object is placed before or after another. These problems may cause the patient to restrict walking due to a fear of falling. For this patient, depth perception exercises using perceptual games or a simulated obstacle course may improve visual–perceptual skills.

The therapeutic nature of activity thus resides in the interaction between impairments within the patient and attributes of activities. Activities are therapeutic if they embody the attributes needed to reduce the specific impairment (control). The activity specialist has the responsibility of matching patient need with activity potential. This match requires an evaluation of the patient to determine the nature and extent of the impairment and an appraisal of activity to ascertain the presence of attributes needed to make a positive change in function. The former process is called functional assessment, the latter, activity analysis. The impairment approach is a clinical or individualized activity program and yields a formal prescription of activity. By virtue of their expertise in formulating the impairment-activity match, activity specialists generally exert control over activity selection. When several activities are identified as potentially therapeutic, activity choices may be offered to the patient.

The impairment approach is applicable as both a preventive and a remedial strategy. Thus an older patient at risk for elbow contracture might be instructed to sit far enough away from a game board so that full elbow extension is required to move the cards. When activity is used preventively, the activity prescription may include activities to avoid as well as activities to do. For example, some patients with arthritis may be advised to stop knitting because of the adverse effects of ulnar deviating pressures caused by prolonged, static hand positioning in holding the needles,[9] and turkish knotting may be recommended as a substitute activity because of its repetitive, nonresistive hand motions, which require radial deviations.

Abilities

The abilities or assets approach to activity is similar to the impairment orientation insofar as it is an individualized approach emanating from a functional assessment and an activity analysis. However, this approach emphasizes patient assets rather than deficits for activity selection. In this strategy no attempt is made to change the impairment. The consequences of disease, trauma, or age-associated dysfunctions are acknowledged as placing restrictions on activity performance and are taken into account in activity programming. However, the major focus is on the function that is left rather than the function that has been lost.[10] Order is conceptualized in relation to functional skill and functional activity. Functional skills are basic abilities, such as muscle strength, dexterity, endurance, problem solving, and vigilance, which underlie a broad range of activities. Functional activities are tasks, such as reading the newspaper, playing cards, knitting, and gardening. Functional deficits and disabilities are concepts of disorder that correspond to functional skills and activities, respectively, and represent undeveloped potential or capacity to adapt.

Programming to a patient's strengths emphasizes intact functioning. Activity is introduced in two distinct but related ways, depending on whether the desired goal is seen as functional skill or functional activity. If the goal is functional skill, activity use imitates the impairment approach, except that activity is prescribed to strengthen an ability rather than to correct a deficit (control). In the case of the previously mentioned stroke patient, for instance, it is recognized that engagement in skilled activity is presently impossible due to the loss of function in the dominant, paralyzed hand. Thus activity is initiated to develop manual ability in the uninvolved, nondominant hand, so that this hand can perform the functions previously carried out by the dominant hand. The basic criterion for activity selection is identical to that of the impairment approach, namely, that the activity be appropriate for achieving the goal (eg, developing manual skill). Thus activities are therapeutic if they embody the attributes needed to improve functional skills. The overall therapeutic process is also the same as that of the impairment approach, with the activity specialist acting as the assessor of function and the prescriber of activity and with activity being used as a means to an end.

The second way in which abilities programming is accomplished aims at developing skill in functional activities (control). Activity use resembles the holistic approach in which the activity has intrinsic value. However, due to the presence of significant impairment, which either precludes participation in prior activities or requires that activity performance be adapted, competence in an activity must again be developed before it can be pursued for its own sake. Thus the stroke patient would learn to apply the manual skill developed through activity exercises to functional activities by performing the functional activity itself. The activity specialist's role is to identify physical, perceptual, cognitive, and social abilities and to preserve and develop them through treatment. To be therapeutic, activities must be meaningful to the patient, offer a chance of success, and promote competence. Activity is selected by the patient based on self-analysis of "wants" and "needs" rather than prescribed by the activity specialist. The patient is encouraged to try out tasks and to discover latent interests and abilities. In the process of self-discovery of activity potential, the patient learns to accept failure and success. Competence emerges gradually as the activity process is mastered. Achievement leads to a renewal of personal identity. The activity specialist guides the movement from skill deficit to skill mastery by arousing interest and by assisting in the identification of achievable options, the exploration of assets, and the development of skill.

To be therapeutic, activities must be meaningful to the patient, offer a chance of success, and promote competence.

Balance

The activity balance approach encompasses a time span that is broader than that of the approaches previously reviewed. This approach is based on the premise that a healthy daily life is normally filled with a variety of things to do. These activities may be grouped into four major categories: self-care, productive, leisure, and rest. Self-care activities encompass those involving care of the self, such as feeding and bathing. Productive activities are those through which an individual contributes to the family and society through paid or volunteer efforts, home management, and caregiving. Leisure activities occupy unobligated time and are engaged in for pleasure and enjoyment. Rest involves napping and sleeping, which serve to replenish physical and mental reserves. Specific activities within these categories might be labeled as physical, mental, or social.

In the healthy individual, life style is organized to provide a dynamic balance of these activity categories and types (order). While this organization is unique for each individual, it incorporates activities in each category and type. The time devoted to each area is adequate for accomplishing responsibilities and for achieving goals. The individual senses that he or she is in control and feels satisfied.

Disorder may be manifested in several ways. One way is the absence or severe constriction of activity in one or more categories or types. The retiree who has failed to find an acceptable work substitute reflects this pattern, as does the frail older person who enters a long-term-care facility and is suddenly left with no meaningful activity. The sedentary patient also illustrates this imbalance.

A second manifestation is a disorganized and ineffective life style such that there is a feeling of loss of control and a sense of being overwhelmed. For example, a recent widow may find it impossible to add the chores previously done by her husband to her own activity schedule. A patient with chronic lung disease or cardiac insufficiency may simply run out of energy before essential tasks get done.

Activity therapy for these problems focuses on correcting the disordered or imbalanced life style (control). Activity is instituted to develop competence in specific tasks, if this is lacking. Thus a workaholic may be taught to play. Activity programming goes beyond this, however, to having an impact on the coordination of daily tasks. Efficiency in daily activities is achieved through energy conservation, time management, task delegation, and habit training. Activity structures the day and has a socializing effect on the patient's life and health. The activity specialist works with the patient to diagnose problem areas; to establish feasible goals; and to set up, implement, and monitor a functional plan of activities.[11]

Stress regulation

In another comprehensive approach, activity is therapeutic if stress is kept within manageable limits (order).[12,13] Much of a person's daily behavior is characterized as being in a steady state—task behavior is routine and adequate, and the associated affect is fairly neutral. This adapted condition exists because the person has the needed competence to meet the demands of everyday life. If the competence level is exceeded, maladaptive behavior results and the accompanying affect becomes negative (disorder).

The activity specialist's role is to monitor stress and to maintain a steady state (control). Activities have a demand quality in relation to the individual. To be done successfully, activities require the person to have certain skills. Each task has its own specific requirements, and to accomplish a specific task, an individual must have the required competencies. By fitting task demands to patients' competencies, stress is kept low. Since the amount of demand a task has for an individual depends on earlier experience with the task, an activity history is a vital component of the activity assessment.

Deviations from the steady state must exceed a certain range before behavior becomes maladaptive. Identifying the acceptable range of deviation for each patient enables the activity specialist to both promote growth and monitor stress. Task demands that are mild or moderate in relation to competence motivate the person to behave in nonroutine ways. This level of demand elicits interest, curiosity, exploratory behavior, and striving. Affect is positive. The task is perceived as manageable, although achievement is dependent on new learning and skill development. Such a task is within the person's zone of maximum performance potential. Task demands that are relatively low in relation to competence, that is, those that fall in the zone of comfort, underchallenge the person. However, behavior remains adaptive, and affect, positive.

The activity specialist regulates stress by keeping activity demands within the zones of maximum performance potential and comfort. Maladaptive behavior can be precipitated if task demands are either too high and hence exceed the zone of maximum performance potential, or are too low and hence exceed the zone of comfort. In the former instance the person is overloaded, in the latter, understimulated.

Activities are regulated in terms of their intensity, frequency, and length. To accommodate fluctuations in energy level throughout the day, activities targeted at the "zone of maximum potential" are scheduled when a patient is most receptive. This might be midmorning for those with Alzheimer's disease, late morning for those with arthritis, and early afternoon for those with depression. Shorter, more frequent activity sessions may accommodate the needs of some, while others may prefer longer and less frequent stimulation. Activity in this context is nonspecific. It includes feeding and dressing as well as reading and painting. Since stress from activity is potentially cumulative, stress-reducing activities need to be planned into the overall activity regimen. In fact, "resting" may require as much planning as "doing," since different people find different things relaxing and since some patients need help to rest. Stress level is monitored by recognizing signs of dysfunctional behavior, such as complaints of tiredness, decreased performance, agitation, refusal, inattention, and withdrawal. These behaviors signal the need to initiate intervention to alleviate stress and to regain health.

DISCUSSION

The five approaches to therapeutic activity for older adults presented in this article are summarized in Table 1. The ordered, or healthy, state was conceptualized as a state of activity and involvement; the absence of impairment; the presence of skill; involvement in a unique, dynamic balance of a variety of activities; and a steady state. Corresponding views of disorder, or the unhealthy state, were inactivity and idleness, impairment, skill deficit, unhealthy configuration or coordination of activities, and maladaptive behavior. As a controlling force or change agent, activity was seen as an end in itself as well as a means of reducing impairment, promoting competence, achieving a balanced life style, and managing stress. Common to all of these approaches is commitment to activity as the vital component of change and growth.

An overall, bilevel model of activity programming emerges from this review of selected activity rationales. In the first level (holistic, impairment, and abilities perspectives), activity is viewed in an isolated, restricted context. The emphasis is on specific actions or tasks. In contrast, in the second level (balance and stress-regulation frameworks), an activity is seen in

Table 1. Approaches to therapeutic activities

Approach	Order*	Disorder†	Control‡
Holistic	Activity and involvement: Overall well-being	Inactivity and idleness: Disuse syndrome	Engagement in activity; provision of a context or group whereby action and achievement can be realized
Impairment	Absence of impairment	Impairment: Loss or abnormality of physical or psychologic structures or functions	Activities with specific attributes are used as a means of correcting, alleviating, or preventing further impairment of function
Abilities	Mastery of functional skills and functional activities	Functional deficits and disabilities	Activities with specific attributes or meaning to the patient are chosen for their ability to facilitate the patient's level of skill from deficit to mastery
Balance	Unique, dynamic balance of activity categories (self-care, productive, leisure, and rest) and types (physical, mental, and social)	Unbalanced or static configuration of activity categories or types	Activity strategies are developed for habit training, time management, conservation of energy, and delegation of tasks
Stress regulation	Steady state or adaptive behavior: neutral or positive effect	Maladaptive behavior: negative or flat affect and stress-related behaviors	Activity selection with demands between zones of comfort and maximum performance potential; activities that reduce stress and are regulated for intensity, frequency and length

*Order – Health state that the activity specialist seeks to establish, restore, maintain, or enhance.

†Disorder – Unhealthy state that the activity specialist seeks to eliminate, alleviate, or prevent.

‡Control – Process by which activity is used to achieve goals, maintain order, convert disorder to order, and prevent disorder.

relation to other activities. Balance is achieved by comparing each activity with other activities. The stress associated with one activity is added to that generated by prior activity participation. These broader, more comprehensive views of activity thus remind us that activity is not something that is confined to the activity room or the activities supervised by an art, dance, occupational, music, or recreational therapist. Rather, for the patient, activity occurs over a 24-hour continuum. Thus the specific actions and tasks instituted under the first level of activity rationales must be successfully integrated into the second-level activity schemes for judicious activity programming.

No necessary incompatibility of approaches is implied in this comparison. A ring tossing game initiated under the holistic rationale would be advisable under the stress-regulation rationale if it were within a patient's competence level, but inadvisable if the competence level were exceeded and the patient became agitated. Similarly, a "marching-while-seated" exercise provided as a physical activity under the balance approach might be appropriate under the impairment orientation for an older patient with generalized weakness but would be contraindicated for one who is recovering from a recent hip fracture. Sanding a breadboard with a bilateral sander simultaneously reduces motor impairment in the affected arm of a stroke patient and increases motor ability in the unaffected arm; however, this exercise could elicit maladaptive behavior from a retired cabinetmaker who views repetitive woodworking tasks as unchallenging and childish. By becoming aware of the differences in these approaches, the activity specialist is sensitized to potential conflicts in their use in converting disorder to order, maintaining order, or preventing disorder. Patients should not have to endure activity programs with conflicting rationales.

Health status is a major determinant of the preferred activity approach or approaches. For the purposes of this discussion, health status may be viewed simply in terms of type and complexity of impairment. If a health condition is discrete and potentially curable, such as an upper extremity contracture or edema, the impairment approach might provide the best option. Conversely, for a chronic, more generalized problem such as heart disease or Alzheimer's disease, the stress-regulation focus might be preferred. Similarly, if the level of impairment enables continued, satisfactory participation in familiar activities, the provision of activities from a holistic rationale would suffice. If such participation is precluded, however, and the patient is at risk for inactivity due to the complexity of impairment, programming from an abilities or impairment rationale would more effectively meet the needs of the patient. While no level of incapacity precludes activity, the more restricted the patient's capacity is, the more difficult activity participation becomes; therefore more direction is required to assure an optimal activity level for a healthy state.

Thus the activity specialist's role in activity selection is reciprocal to the patient's role and is dependent on the patient's health status. Patient control over activity selection is preferable, since it elicits greater involvement and cooperation. The exercise of the choice is particularly important in institutional settings in which opportunities for control are often minimal. Under such circumstances the exercise of control in even small things, such as taking care of plants, has been shown to have positive benefits.[14] The activity specialist is justified in taking charge of activity selection only if the patient is unable to act discriminatively. This state may take the form of an inability to decide what to do, lack of motivation to become more active, failure to start an activity, lack of persistence, or confusion in knowing what is feasible. Considerable skill is required to interest those who do not care to be interested and to find feasible options for those with

The activity specialist's role in activity selection is reciprocal to the patient's role and is dependent on the patient's health status.

severe, multidimensional disabilities. Even when activity is prescribed, the creative practitioner usually offers several alternatives to the patient that are in keeping with the patient's interests. Coercion and passive stimulation are reserved for the severely impaired. As the patient's decision-making capabilities change, either improving or deteriorating, the activity specialist relinquishes or increases control accordingly.

Regardless of the therapeutic approach taken, the activity specialist must combine activity expertise with the "therapeutic use of self" to elicit self-directed programming or to achieve compliance with activity prescriptions and schedules. Each person possesses a healing power that emerges when he or she reaches out to the patient through acceptance, concern, empathy, and genuineness, rather than just professional ritual and technique. It is through the human quality of the practitioner–patient transaction that patients are helped to understand their capabilities and needs. When patients know that the practitioner feels with them, cares about them, and understands their reasons and reactions, they are more likely to listen to the practitioner, want approval, accept hope and encouragement, and be open to suggestions. By "pausing to care," the activity specialist can win the confidence of patients and can mobilize and release the human forces that promote the health–activity linkage.

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A Pilot Study on the Effect of Rapport on the Task Performance of an Elderly Confused Population

Linda Porszt-Miron, Majka Florian,
Jean Burton

Key Words:

- Alzheimer's disease
- Dementia
- Rapport
- Task Achievement

Lynda Porszt-Miron, B.A., B.Sc., O.T.(C), was a fourth year occupational therapy student at Queen's University at the time of the Study. She is presently an Occupational Therapist at Peel Memorial Hospital, Brampton, Ontario.

Majka Florian, B.Sc., O.T.(C), was a fourth year occupational therapy student at Queen's University at the time of the study. She is presently an Occupational Therapist at Kingston Psychiatric Hospital, Kingston, Ontario.

Jean E. Burton, M.Ed., B.A., O.T.(C), is a Professor in the Division of Occupational Therapy, School of Rehabilitation Therapy, Queen's University, Kingston, Ontario.

Abstract

Rapport has been viewed traditionally by the helping professions as a prerequisite to effective interaction between therapist and patient. Clinical observations indicate that confused elderly residents of a Home for the Aged have the capacity to establish warm personal relationships with their therapists and caregivers. In order to determine if this apparent rapport has a positive effect on task performance, six confused subjects were assigned either to an experimental or control group. They were administered the Picture Identification Task before and after receiving a program designed to establish rapport with their respective leaders. All testing was done by the experimental group leaders. Thus the experimental subjects had rapport with the administrators, while the control subjects did not. The data indicated that experimental subjects decreased their inappropriate behaviours, were able to respond quicker, and made better use of nonverbal test cues at post-test. Control subjects did not demonstrate these changes. It was concluded that rapport can facilitate some task behaviours despite cognitive impairment.

A rehabilitative, rather then custodial approach to management is being used when dealing with people diagnosed with Alzheimer's Disease. This approach is resulting in multi-disciplinary involvement and search of new rehabilitative treatments. Over the past five years, senior occupational therapy students on part-time placements in a Home for the Aged reported that within two weeks confused residents with a diagnosis of Alzheimer's Disease were greeting the students nonverbally and some were indicating awareness that the students were associated with a pleasurable activity. Despite the elderly confused resident's characteristics of memory impairment and disorientation, clinical observations indicated that a positive emotional bond does develop between this patient population and members of health care staff, an observation supported by Edelson and Lyons (1985). Traditionally, occupational therapy recognizes rapport as a vehicle to successful rehabilitation. Thus, it was decided to explore the effect of rapport on the performance of a simple task by elderly residents having a diagnosis of Alzheimer's Disease. While it was recognized that cognitive limitations would be present, it was anticipated that rapport could still be influential in terms of improved task performance.

Literature Review

Central to the philosophy of all helping professions is the concept of rapport or therapeutic relationship. It

It has traditionally been assumed that mutual trust and positive regard between therapist and patient will enhance the outcome of treatment or counselling.

has traditionally been assumed that a relationship of mutual trust and positive regard between therapist and patient will enhance the outcome of treatment or counselling. This belief also guides therapist-patient interaction in occupational therapy (Mosey, 1981; Reed & Sanderson, 1983; Yerxa, 1983).

In 1979, Ford reviewed the literature on therapeutic relationships and cited a number of studies in which the characteristics of this relationship were analyzed. The characteristics of the therapist were identified as "verbal and nonverbal encouragement, involvement, concern and respect for the client" (Ford, 1978, p. 1311). These characteristics were more significant for the client than the therapist's perceived competence or authority (Sweet, 1984).

A study conducted by Rosendale and Ross (1982) investigated the effects of rapport on task performance of 50 normal elderly subjects. Subjects were randomly assigned to experimental and control groups. Experimental subjects received attending behaviours from the therapist while completing the Goldfarb Mental Status Questionnaire. Control subjects completed the questionnaire without experiencing attending behaviours. The results showed increased performance ratings for the experimental group. Despite the commonly held belief that rapport facilitates compliance, cooperation and a desire to do one's best, little research has been done to substantiate this belief. The study by Rosendale and Ross (1982) is the only one of its kind involving elderly subjects.

Achievement of rapport with an elderly client requires the therapist to be more personal, sharing the client's interests and feelings, and being more open about himself or herself, in contrast to the "professional" or more objective or distant style usually adopted (Burnside, 1978; Goldstein, 1982). In attempting to establish rapport with the client who has a diagnosis of Alzheimer's Disease, the therapist faces the added challenge of how to convey this more personal style of relating to a person for whom communication is problematic. The confused individual's efforts to converse are often incoherent and undermined by word finding difficulties. Reception of information is also impaired (Welford, 1980). Macdonald (1986) provides guidelines for the improvement of communication. She particularly stresses nonverbal communication as a productive technique when language skills are impaired. Gazda (1978) reports that 65% of the meaning of a message is derived from nonverbal communication, and in some cases the nonverbal components may even override the verbal content. This implies potential for successful communication with the confused elderly if specific use is made of gestures, mime, demonstration and voice modulation to convey meaning.

Gazda (1978) describes a series of attending behaviours which convey acceptance and trust, the basic components of rapport. These include eye contact, touch, relaxed posture, and facial expression appropriate to the emotional tone of the interaction. The therapist should also show alertness and enthusiasm. The use of these techniques, and the importance of interaction on rapport with the confused elderly have been discussed by some authors (Hoffman, Platt, Barry & Hammill, 1985; Willians, 1986). Edelson and Lyons (1985) state that the confused elderly will respond to the emotional content of a message. The outcome of this responsiveness is likely to be a maximizing of function. Furthermore, both Edelson and Lyons (1985) and Griffin and Matthews (1986) contend that successful rapport with the elderly will result in performance which more accurately reflects confused elderly patients' abilities and limitations.

In summary, the capacity of the confused elderly patient to establish a relationship with a therapist or caregiver has received support in the literature. Techniques to improve communication with these patients and enhance the development of rapport have been described. The relationship between rapport and performance has been the focus of very limited investigations although it is commonly believed by the helping professions that rapport positively influences performance.

Methodology

A quasi-experimental design was used, in which control and experimental groups received pretesting, a four week intervention activity program and post-testing. Both the pre and post-test consisted of four measurements taken over a three week period. The use of a control group was intended to control for those effects due to the intervention activity program and possible contamination of the results due to the Hawthorne effect. All testing for both groups was conducted by the two fourth year occupational therapy students. These two students also led the experimental group, while two third year occupational therapy students led the control group. Rapport was developed between group leaders and their respective group through the use of attending behaviours as outlined by Gazda (1978). Thus, the experimental group was tested by individuals with whom they had developed rapport. This was not the case for the control group as the fourth year students were unknown to them.

The one hour intervention program which was conducted three times a week consisted of activities such as light exercises, arts and crafts, cooking and music. No activity which resembled the test instrument was included in this program.

The test instrument was designed to be unfamiliar to the subjects to ensure that it would not elicit automatic responses. It was felt that automatic, functional responses such as eating and dressing, would not provide a good measure of rapport effects. The instrument consisted of a Picture Identification Task (PIT), an observation checklist and administration/observation protocol. The PIT was based on four cards selected from the Association Picture Cards III of the Developmental Learning Materials (1969). In order to identify the level of verbal and non-verbal cueing required to elicit a behavioural response, the PIT instructions were graded from abstract to concrete. "Gradation of Cue" (GOC) was the term given to the levels of cueing as follows:

GOC level 1, a verbal cue: "I have a picture for you" (card displayed)
GOC level 2, a non-verbal cue: card is moved closer to subject
GOC level 3, a general verbal/non-verbal cue: "can you tell me what is in the picture?" (pointing to card)
GOC level 4, a specific verbal/non-verbal cue: "can you tell me what this is?" (circling specific object on card.)

A thirty second interval was allowed for subject's response before proceeding to the next GOC level.

The observational checklist included subjects' physical responses such as reaching, touching, scanning, and verbal responses such as picture description and request for information. The structure of the observation checklist allowed documentation of a variety of response behaviours according to the GOC level in which they occurred. Response behaviours provided information such as attention to task, frequency and speed of physical and verbal responses and ability to name an object.

A sample of 15 confused residents of a Home for the Aged was selected by nursing staff on the basis of a diagnosis of Alzheimer's disease and a rating of "dementia" on Folstein's Minimental Status scale. These 15 were administered the PIT and six subjects with lower mid-range scores were selected, thus eliminating extreme scores. The six subjects, all female, who were between the ages of 89 and 96, were matched in pairs according to their level of cooperation and word-finding difficulty. One member from each pair was randomly assigned to the experimental group. The remaining three subjects formed the control group.

Results

Individual behaviours from the observational checklists were grouped into the following categories: verbal/appropriate, physical/appropriate, verbal and physical/inappropriate, number of nouns, time to first correct verbal response, and time to first physical response. Given the small sample size inferential statistical analysis was not possible. Similarly case by case presentation of data would not have demonstrated the overall implication of the effect of rapport. Experimental and control groups were therefore compared for emerging trends and/or patterns with respect to each group member's baseline.

A pattern of increased consistency in responding within the verbal/appropriate category was seen for the experimental group. The experimental subjects appeared able to respond to the non-verbal GOC level 2, thus making their responses more consistent, whereas the control subjects could not.

In the category of verbal and physical/inappropriate, a pattern emerged of a larger decrease of inappropriate behaviours in the experimental group than in the control group. The experimental group was also able to decrease the time required to perform the first correct physical response. In contrast the control group subjects increased their time in this category.

Data from the category of physical/appropriate behaviour did not suggest any differences between groups. As the focus of the PIT was not on physical behavioural responses, the result in this category is not surprising.

For the category of time to first correct verbal response the data did not suggest any pattern. This may have been due of the word-finding difficulties which are characteristic of the population under study.

Increased consistency of responses was noted in the number of nouns category. This was again due to the ability of the experimental group to pick up nonverbal cues.

Informal observations which were recorded by the four leaders during each session, supported the experimental findings. As rapport developed though the use of activities and attending behaviours, the subjects became more cooperative. They greeted the group leaders in a warm and friendly manner, offered food and began to display more appropriate social skills. Inappropriate behaviours, such as spitting and crying decreased.

In general, results from the PIT suggested that the experimental group was more consistent in responding across the GOC levels, responded more frequently to the non-verbal GOC level 2 and showed a greater decrease in inappropriate behaviour than the control group. The key factor in the experimental group's performance appeared to be the ability to perceive and act upon the non-verbal cues.

Discussion

The results indicate that in these subjects, rapport had some positive influence on task performance. However the small size of the sample precludes generalization of these results. The characteristics of the Alzheimer patient require that individual or small group activities be used in programming, so that the results of this pilot study would have to be replicated on numerous small patient samples before conclusions can be drawn on the role of rapport in this population.

Intervening variables were controlled as far as possible by the study design. Nevertheless, the effects of an upsetting or stimulating event on one subject could have skewed the results again due to the small sample size.

Establishing rapport as an enhancement of nonverbal communication skills, may be seen as a useful tool in improving the quality of life for the confused elderly.

Given that the activity involved in the testing situation had no relation to the activities used during intervention activity program, it is believed that learning played no part in the results, and that rapport was successfully isolated as the independent variable in that all factors were identical for both groups except the establishment of rapport with the administrators of the P.I.T.

The positive influence of rapport upon task performance of the subject under study appears to be due to an increase in consistency of responses and a decrease of inappropriate behaviours. A recurring theme in the findings was that of the importance of rapport in enabling the experimental group subjects to respond to the nonverbal cue. It may be that within the relationship of rapport, nonverbal communication skills are heightened. Edelson and Lyons (1985) state that the confused elderly individual possesses a nonverbal style of communication which is unique to himself and that he may be best reached through a nonverbal mode of communication. Thus establishing rapport as an enhancement of nonverbal communication skills, may be seen as a useful tool in improving the quality of life for the confused elderly.

Rapport can be seen as having a reciprocal effect for the caregivers. Improved communication provides caregivers with a sense of satisfaction and effectiveness in their challenging role.

Summary and Recommendations for Further Research

Experimental and control subjects' responses to a Picture Identification Task (PIT) were tested before and after participating in a program designed to establish rapport. Results suggested that rapport with individuals who administered the PIT enabled experimental subjects to improve their performance in several behavioural categories.

Limitations of this study are a small subject sample, a measure (PIT) which has no known reliability or validity and the possibility of investigator bias. Therefore the results of the study can be viewed only as possible trends. However, rapport does appear to have some positive effects on task performance, as is commonly assumed.

As indicated earlier, further studies using a larger pool of small subject groups, will be necessary to validate the findings of this study. A design which would allow for interpretation of results through the celeration line approach would yield information about rapport establishment and extinction. Further research can explore the influence of gender in the caregiver-client relationship as the findings may determine staffing preferences for optimal client care. The use of nonverbal communication among the successful versus problematic caregiver-client/relative duos can be explored in the community. It may be that the stay of an affected individual in the community could be prolonged by teaching the care-giver nonverbal cueing methods.

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Résumé

La relation a toujours été considérée dans le milieu des personnes soignantes comme un prérequis à l'interaction efficace entre le thérapeute et le client. Des observations cliniques démontrent qu'il est possible pour les bénéficiaires confus d'une résidence pour personnes âgées d'établir une relation personnelle chaleureuse avec leurs thérapeutes et leurs dispensateurs de soins. Afin de déterminer l'effet positif de cette relation apparente sur la performance des tâches, six sujets confus ont été assignés soit à un groupe expérimental soit à un groupe témoin. Ils furent soumis au test d'identification des tâches par l'image (Picture Identification Task) avant et après avoir bénéficiés d'un programme destiné à établir une relation avec le responsable de leur groupe propre. Tous les tests furent administrés par les responsables du groupe expérimental. Ainsi, les sujets du groupe expérimental avaient déjà une relation avec les administrateurs du test, ce qui n'était pas le cas pour les sujets du groupe témoin. Les données indiquent que les sujets du groupe expérimental ont diminué leurs comportements inappropriés, ont pu répondre plus rapidement et ont fait meilleur usage des indications non verbales du test à la deuxième épreuve. Les sujets témoins n'ont pas fait état de ces changements. En conclusion: la relation peut faciliter la performance des tâches en dépit de l'atteinte cognitive.

Poster Session 3

Ruth E. Plautz

Beth M. Timen

Seating/Positioning of the Institutionalized Elderly

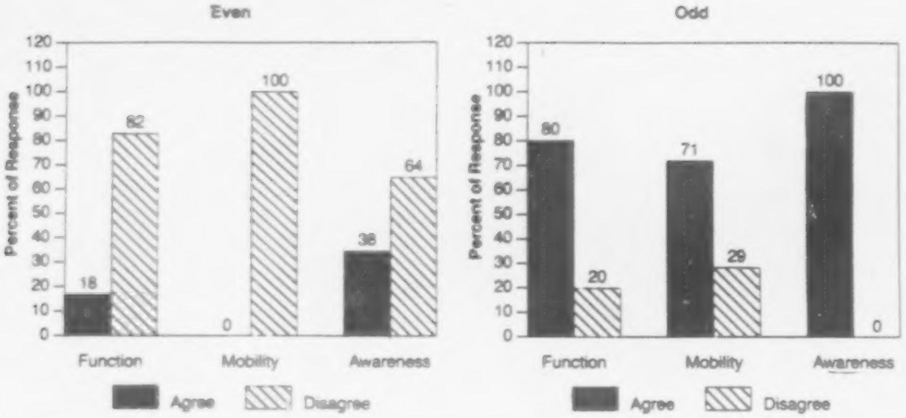
In the past, studies, research, and development of innovative seating devices have been geared toward the pediatric population. Our literature search has revealed a dearth of geriatric seating research.

The increasing need for geriatric research and subsequent intervention becomes essential as 10 percent of all individuals age 75 and over, and 22 percent of all individuals age 85 and over have shown to be in nursing homes (Pearson and Wetle, 1981). In caring for the elderly population, it has been shown that the influence of expectations and attitudes of geriatric caregivers is critical to treatment results (Gustafson, 1983).

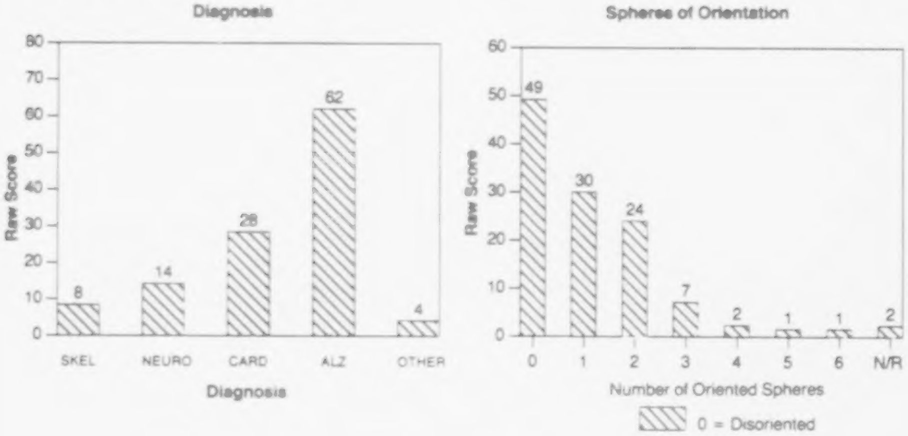
It should be noted that poor posture is not a function of the normal aging process, or a necessary byproduct of institutionalization. Unfortunately, our experience indicates that haphazard or negligible intervention in positioning of those institutionalized elderly who spend large amounts of time seated fosters increased disabilities and dependence. Thus postural intervention would benefit and ideally should be initiated for all individuals who spend substantial periods of time in a chair. Postural intervention is especially important for those patients who do not have adequate musculoskeletal, proprioceptive, or cognitive ability to readjust their position. This encompasses a large percentage of the institutionalized elderly. Intervention has been shown to improve function and contact

Ruth E. Plautz, OTR/L, is Chief Occupational Therapist and Beth M. Timen, LPT, is a Physical Therapist at the Menorah Park Center for the Aging, Cleveland, OH.

Pilot Attitudinal Survey of Staff Perceptions



Needs Assessment (116 Charts)



with the environment, and aid in the prevention of physiological compromises that can result from poor positioning.

While establishing a seating clinic in our institution in response to the growing need for postural intervention, we could only conjecture as to the broad spectrum of needs as well as potential benefits to be derived from improved positioning of our population. Our needs assessment of those referred to our clinic revealed deficiencies in current seating positions of both physically and cognitively impaired individuals. Further, the actual experience of our seating clinic has been that the majority of our unsolicited referrals for positioning intervention have come from our facility's units with more regressed patients. This fact led to our initiation of a chart review of the 116 residents on these units. Our findings, as shown on the accompanying graphs, reveal a generally functionally dependent, non-ambulatory population with myriad diagnoses. Mentation is decreased in the vast majority of these residents. In short, postural intervention for these people is necessary to prevent further cardiovascular, pulmonary, and musculoskeletal decline as well as to increase their potential for making eye contact with their environment.

An added bonus appears to be the improvement of the staff's perception and thus, we hope, increased staff interaction with these residents. Our pilot attitudinal study has indeed indicated a difference in staff perception based on positioning in the wheelchair.

To facilitate improved seating/positioning in our facility, we used myriad approaches. These approaches run the gamut from staff-produced foam cutouts and supports to a segmental seating device. Makeshift seating or generic devices certainly provide sufficient functional or positional improvement, but have proven difficult to maintain in an institutionalized setting with a multitude of care givers. However, we have found that a segmental, modular orthotic device, OrthoConcepts Seating System, which can be altered by the therapist or orthotist, to be the most successful. This device provides the greatest potential for consistency in continuity of positioning. When the current patient no longer is able to benefit from it, it can be readjusted to meet the needs of another patient. Both ease of maintenance and versatility are important factors in institutional or multi-caregiver settings. OrthoConcepts Seating System has proven to be the most easily maintainable as well as versatile seating device we have encountered.

Seating system referenced in text available as follows:

OrthoConcepts Seating Systems
545 Mayfield Road
Cleveland, Ohio 44124
(216) 449-8222

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Scientific/Technical
Session 104-A

Cynthia F. Epstein

Patricia M. Sadownick

Specialized Seating for the Institutionalized Elderly

Prescription, Fabrication, Funding

Out-of-bed seating for the severely involved, institutionalized elderly is of major concern to occupational therapists. Technological advances have provided multiple options for wheelchair adaptations, some of which can be quickly and effectively used by the therapist on site. Other more sophisticated adaptations require fabrication and assembly through a vendor. The expanding array of equipment, materials, and supplies requires increasing familiarity with available options so that knowledgeable decisions can be made. Appropriate prescription and fabrication must be followed with adequate funding. Therefore, today's therapist must be equally skilled in identifying funding streams and obtaining the necessary monies for specialized equipment and adaptions.

Evaluation and prescription issues for out-of-bed seating must consider both the needs of the individual client and the readiness of the facility to accept complex and variable components in a seating system. A support team within the institution must be committed to effective use and maintenance of the specialized seating provided for the client. Without team cooperation the seating system, carefully and knowledgeably designed by the therapist, will not be used effectively—if at all! An important part of the evaluation process for the therapist must therefore be consideration of the human and non-human environments

Cynthia F. Epstein, MA, OTR, FAOTA, is the Executive Director of Occupational Therapy Consultants, Inc., Bridgewater, NJ.

Patricia M. Sadownick, MS, OTR, is Director of Occupational Therapy at Clove Lakes Nursing Home and HRF, Staten Island, NY.

which support the positioning program designed for the client (Epstein, 1988).

The complex problems in providing seating for this elderly population require that the therapist have space, appropriate supplies, and access to special equipment in order to evaluate the client during several sessions. Without such resources, subtle issues that affect functional positioning may be missed, thereby causing serious problems after delivery of the system. As an example, a client with agitated behavior on the nursing unit may be characterized by repetitive movements of the lower extremities. Using an unpadded laptray as part of a seating system for such a person places them at risk for bruises and tears of the skin.

Supportive environments for the therapist and client within the institution must be complemented by a pool of knowledgeable vendors and an understanding of funding options. Use of specially designed forms, such as the one recently developed by a seating/wheeled mobility task force (Electronic Industries Foundation, 1988), will help assure approval of costly equipment.

Prescription

Institutionalized elderly present complex evaluation issues. Staff referral for positioning may be made due to "constant sliding out of chair." The therapist's concerns, however, are multiple and specific. Such factors as tone, posture, skin integrity, continence, sitting tolerance, and movement are primary. Orthopedic considerations, including kyphosis, scoliosis, dislocated hips, flexion/extension deformities, must be delineated. Complex diagnoses, including osteoarthritis and osteoporosis, and long histories which may include fractures, decubiti, multiple bruises, and skin tears are of concern. Functional abilities to perform such tasks as self-propulsion, transfers, eating, communication, and participation in activities must be ascertained (Gans, Hallenborg and Trefler, 1984).

Evaluation considers the methods for normalization and stability, beginning at the pelvis. Such problems as obliquity, tilt, and fixed deformity require seat and back modifications. These may include a seat with a special cushion, hip guides, abduction wedge, anti-thrust roll, seat belt, or bar across the anterior-superior iliac spine (Cooper, 1987; Margolis, Wengert & Kolar, 1988). The sling back may be replaced with a firm back and contoured with pressure responsive foam, lumbar or shoulder rolls, lateral supports, and possibly a specially designed headrest (Bergen and Colangelo, 1982). Significant scoliosis and kyphosis require more supportive environments, such as those available through Contour-U and Foam-In-Place Systems (Bergen, A., 1988; McNaughton, K., 1988). Angulation/Orientation-in-space, now available for the adult population, must also be considered for those in need of gravity assistance to maintain a stable and normalized seated position. Such equipment allows control and appropriate positioning for head, trunk, pelvis, knees, and feet (Rego, 1988).

Severely involved, institutionalized elderly are at high risk for pressure sores. Seat cushions must therefore be responsive to the particular needs of the individual (Garber, 1979, 1985). A wide variety of wheelchair cushions are available, giving the knowledgeable therapist many options and a varied price range.

Fabrication

The standard size wheelchair, found in most institutions, can easily serve as a basis for adaptive seating inserts. These adaptations can be fabricated within the occupational therapy department or with the assistance of the facility's maintenance department. More complex seating will require the efforts of a seating team and fabrication by an outside vendor. In either case, the therapist must be knowledgeable regarding the variety of materials and component parts that are available on the market to provide the needed adaptations.

Low-tech adaptations allow a therapist on-site gradually to modify the wheelchair while monitoring the client's response to each change. As long as the modifications are simple, easily applied, and understood by staff, they are well accepted and provide a quick, inexpensive, and effective solution.

Materials such as plywood; polyurethane; viscoelastic and ethafoams; hook and loop or webbing straps; and special hardware, fabric and vinyls offer many creative solutions to the knowledgeable therapist (Shafer, A. & Epstein, C., 1987).

Inexpensive, commercially available adaptions are also available to assist therapists in quickly resolving positioning issues. Simple to apply, easily understood by staff, and fabricated to withstand use in an institutional setting, these positioners are cost-effective solutions and can be kept in stock as part of the occupational therapy supplies (Epstein, C. F., 1988; AliMed, 1988).

Those clients requiring more complex seating should be seen by the seating team in conjunction with a knowledgeable medical equipment dealer. Decisions regarding linear vs. contoured, upright vs. angulation in space, fixed vs. adjustable hardware, foam vs. gel, and multiple other options can be considered by the team as they observe client response to seating modifications (Randall, M., 1984; Trefler, E., 1984). It is preferable to simulate the projected seating environment so that client response can be assessed over a number of days.

Funding

Without funding, the time, energy, and multiple resources devoted to prescription and fabrication will be for naught. Inexpensive and readily available adaptations require support from within the facility. Funds may be provided through nursing or maintenance budgets, or directly to the occupational therapy budget. In some cases, it is possible to have client families support the needed equipment.

For more expensive and complex equipment, funding is sought through third-party payors or client families. When third-party payors such as insurance companies, Medicare, and Medicaid are involved, a comprehensive report and justification for the needed equipment are required. A well-written, clearly presented report with accompanying pictures and data on comparative equipment that was considered but not recommended will help to obtain approval for costly inserts. In addition, the use of a facility wheelchair frame, into which the insert can be fitted, will go far in obtaining the needed approval.

Summary

Today's technological advances in seating allow therapists servicing institutionalized elderly to provide effective positioning for this needy population. Clients who are well positioned will increase their participation in and functional performance of important self-care skills. Interaction with the environment, awareness, and communication with peers and staff will increase. Staff support and interest in these severely involved elderly will be enhanced in direct response to the client's greater independence and the decreased staff time required for repositioning.

Using "low- and high-tech" approaches to seating, the creative and knowledgeable therapist can expand services to this population. Funding sources from within the institution, as well as from client families and third-party payors, will help maximize the amount of adaptive seating available in any given facility.

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Item 7

Use of Restraints in Nursing Homes

L. Gregory Pawlson, M.D., MPH
Professor of Health Care Sciences
Medicine
Health Services Administration

The first point I would like to make echoes what you have heard, from a different viewpoint in much of the earlier testimony. From an academic or scientific perspective the best that can be said about the use of physical restraints is that the indications for the use of physical restraints are unclear and the evidence for efficacy and safety of physical restraint is essentially non-existent. I will return briefly to this point at the end of my presentation since Dr. Lois Evans will focus more extensively on the scientific evidence.

The main focus of my testimony is less immediate but in the long run, more important if we are to avoid similar problems in the future. Unfortunately these issues do not lend themselves to the use of dramatic examples, as with a patient who incurred injuries because they were wearing a restraint or who suffered a fractured skull because they weren't. My focus is on the real issue that confronts us today: how do we provide, at reasonable cost, a safe, appropriate and humane nursing home environment for persons with both cognitive and physical impairments?

As a number of speakers today have eloquently indicated the use of personal restraints is an inadequate answer to this problem. Their suggestion that we modify the environment of care rather than restraining the person is simple and profound. However this rather self-evident finding presents a major challenge to most traditionally trained health professionals.

This challenge brings me to the major point of my presentation: Care in the nursing home is sub-optimal largely because neither health professions educators nor health care researchers have created a reasonable approach to developing or evaluating the care of individuals residing in nursing homes. We have argued whether the medical or social model of care should apply to nursing homes when we should have recognized that neither is directly applicable. We have been smug and self-satisfied as have forced hospital medicine and nursing and community social work paradigms on the nursing home environment. The result is our current non-system of care in our nursing homes.

The use of physical restraints is a direct result of the medical and nursing approach to nursing home care and the resultant over-reliance on technology applied to the individuals rather than the environment in an effort to manage problems in the nursing home. The focus on technology applied to individuals is very important in terms of our investment in basic research which may someday lead to methods to control or prevent the degenerative and dementing diseases that result in fragility. The error is that this approach limits our thinking about modification of the environment rather than of the individual. Modification of the environment is all too often simply overlooked.

Yet our colleagues in social work or rehabilitation have also contributed to the problem by failing to adapt their own approaches to the care of nursing home patients. It is obvious to everyone who in engaged in providing health care services to older persons that no single discipline is sufficient to provide comprehensive care to this group. The use of the "interdisciplinary teams" has been widely seen as a solution to providing optimal care to older persons. Indeed federal regulations require that the care of individuals in nursing homes is reviewed on admission and thereafter on a quarterly basis by certain professionals. Most often a group of professionals, usually including nurses, social workers and in some instances physical and occupational therapists dieticians and physicians, are brought together to develop or review the plan of care. This expensive and time consuming activity has often failed to arrive at creative solutions most often in my experience because of the lack of leadership and the previously noted reliance on interventions limited to patient applied technology.

A second and equally fundamental problem is the lack of support for research to evaluate the safety, efficacy, effectiveness or appropriateness of any technology applied to functionally and cognitively impaired older persons.

There are several hopeful developments which may enhance the effectiveness of our approach to caring for cognitively and physically impaired individuals in nursing homes. First as noted by an earlier panel, the implementation of the nursing home related portion of OBRA 87, creates a process for defining a care planning process that is linked to a careful and thorough assessment of the patient's needs. Secondly the continued refinement of comprehensive geriatric assessment as a tool for defining the health care needs of older individuals will add to our ability to specify and target problems in some nursing home residents. These innovations will not however be effective unless there is a concerted effort through both continuing education and curricular change in health professions education of the importance of and possibility of modifying the environment as well as the patient.

It is always far easier to identify problems than to find solutions. Let me outline a few of the changes that I think might lead to better care in our nation's nursing homes. We need to develop approaches that rely on modification of the environment of nursing home care to fit the need of patients not the reverse. The nursing home environment was developed and modeled after the hospital at one extreme or the rest or retirement home on the other. What we need is an integrated model which recognizes the substantial medical and nursing needs of the patient as well as the social and developmental needs.

We need to have true interdisciplinary approaches which embody new modes of care revellent to resident needs and not simply each discipline trying to force its own limited model of care on the nursing home resident.

To accomplish these goals health professions educations must establish new models of education Teaching nursing homes by NIA and Robert Wood Johnson Foundation have helped but have only established a beginning to a new, and more appropriate approach to nursing home care. To maintain even this modest beginning will require a refocusing of some existing funding for nursing, medical, and rehabilitation education and research on the nursing home setting of care.

In terms of specific recommendations:

1. The problem of providing a safe, yet minimally restrictive environment for frail older persons with multiple functional impairments is serious and widespread and merits substantial attention from funding agencies, researchers and clinicians.

2. The National Institute on Aging, the National Center for Nursing Research and private foundations should develop a substantial, coordinated program of research into the development of safe and effective methods for reducing risk of injury, and enhancing the function of older persons with cognitive impairment, especially those with behaviors that lead to patient and staff distress. This research should include a careful investigation of the efficacy of existing approaches including physical and chemical restraints in addressing the problem.

3. The GAO should be asked to do a review of the existing evidence of the safety and efficacy of existing approaches to behavioral problems seen in older persons with cognitive impairment.

Although this testimony is geared to educational and research it is impossible to address the problem without a consideration of current Medicaid reimbursement policies. Many of the current alternatives to physical or chemical restraints have been developed in nursing homes with relatively homogeneous ethnic or cultural populations or with sources of revenue substantially more generous than Medicaid. In addition, there is no guarantee that research will uncover techniques that will be both safer and more effective as well as less costly than restraints. This would suggest that there must be a willingness on the part of the American people, as reflected by policy decisions made by state and federal legislators, to provide adequate funding in the Medicaid program to provide more effective alternatives to physical or chemical restraints.

To expend large amounts of time and effort on research and educational approaches in the absence of such a commitment is likely to be of little lasting benefit. In the last analysis, it is the plight of the cognitively impaired older person, regardless of the setting, that must be the focus of our efforts.

The other fundamental problem which I alluded to is the lack of funding to develop and then to evaluate the safety, efficacy, effectiveness and appropriateness of approaches to safe and humane care of nursing home residents. Recent studies of the patterns of medical care in the United States have produced strong arguments to support the position there is substantial over-use of certain diagnostic and therapeutic procedures. This is also increasing awareness that some diagnostic and therapeutic procedures in relatively widespread use, are little or no benefit. These findings are especially problematic in regard to the care of the frail elderly.

First, the population of frail older persons is very heterogeneous and both the potential risks and potential benefits of diagnosis and treatment are often increased. Secondly, there is a relative dearth of clinical and health services research focused on the use of diagnostic and therapeutic measures in frail older persons. Finally, because of public financing of the care of older persons, their care is receiving increasing public scrutiny.

The use of physical and chemical restraints on persons residing in nursing homes is a prime example of the human and economic costs of what happens when we fail to evaluate health care technology. Several articles have appeared in the Journal of the American Geriatrics Society and elsewhere which have demonstrated wide-spread use of both chemical and physical restraints in nursing homes, rehabilitation units and hospitals. All too often the indications for use of the restraints were either unclear or even absent, at least from the chart.

From my own experience, as well as published but largely anecdotal evidence, physical restraints or psychotropic drugs are often "ordered" by physicians following a conversation or phone call from a beleaguered nursing staff trying to cope with a patient with cognitive impairment who appears to be a danger to themselves or others. An unproven approach to what is often an acute situation, becomes a chronic therapy because we feel that "something" has been done to solve the problem. Yet there are a disturbing number of examples where there has been injury or even death as a direct result of the use of physical or chemical restraints.

Several recent and more carefully designed research projects have documented emotional distress in physically restrained patients, and an increased incidence of falls in those on psychotropic drugs. Although the lack of appropriate control groups limit interpretation, the use of restraints has also been associated with reductions in mobility, continence and social interaction. Even more disturbing is the lack of clear indications for the use of physical restraints and unequivocal evidence for at while the reasons most often cited for the use of restraints is to prevent patient injury or to allow "necessary" treatment to occur, I am unaware of any study that has clearly demonstrated any efficacy of restraints for those indications.

Reviews and the development of guidelines by groups such as the Clinical Practice Committee of the American Geriatrics Society will no doubt be helpful in guiding this debate. Given our current degree of uncertainty of the benefit of current restraint modalities there should at least be regulations that limit their use to situations that fulfill the following criteria:

1. Where there has been careful documentation of a substantial danger to the patient (or other patients).

2. Where after careful review, no safer or more effective alternative is available in the particular setting in which the behavior occurs.

3. No alternative setting is available to the patient which could provide a safer and less restrictive control of the problem.

4. Careful documentation that the chemical or physical restraint has substantially reduced the danger or behavior and that the minimal effective dose or frequency of restraint is being used.

5. Ongoing review of the situation to determine if safer and more effective alternatives are available or if there has been a change in underlying behavior.

6. Removal or discontinuation of chemical or physical restraints at reasonable intervals to reaffirm the need for and effectiveness of the procedures.

In summary, while a ban on current physical restraints might indeed yield a net benefit (and thus merits active, reasoned debate and consideration), it will not solve a more fundamental, and important problem which is to provide more effective care to those older persons with cognitive impairment. The fundamental problem is that we have failed to invest sufficient resources to create an environment of care that is appropriate to the nursing home and to evaluate the safety, effectiveness, and cost-effectiveness of existing approaches to caring for individuals with cognitive and physical impairment who reside in nursing homes. Likewise, there has been a paucity of research into developing new approaches or technologies that offer significant advantages over existing methods.

Item 8

US Senate Special Committee On Aging
Untie the Elderly: Quality Care Without Restraints
National Symposium

December 4, 1989
Washington, D.C.

Panel: Looking Ahead - Changing Practice Through Training, Education, and Research

L.Evans: "Current Status and Needs for Research"

As with many problems affecting the cognitively impaired, frail elderly, that of physical restraint has received little attention until recently. Thus far, however, it has generated much emotional response but little factual data through systematic research. Since 1973, only 18 studies have been published in the literature, the bulk of these in the past three years (See Figure 1). As can be seen, studies on physical restraint of the elderly have suddenly become a "hot topic," as the standing room-only symposium on restraints at the recent Gerontological Society of America meeting attests.

Of the 18 reported studies, six were conducted in a hospital setting[1-9], nine in long term care[10-15], and three in a combination of settings[16-18] (Figure 2). None were based in the community, although there is anecdotal evidence that older adults are also not safe from restraint use in the home. The research has primarily been patient-focused (Figure 3), with only one examining staff decision-making behavior[18], one facility practices[12], and four a combination[4,10-11,9]. All study designs have been descriptive (Figure 4). Of these, seven were small exploratory studies[4,9-11,13,15,18]; six were prospective, five in hospitals[1,3,5,8,16] and one in the nursing home[14]. Two were surveys[12,17], and 3 were pre-post, one group evaluations of change in practice[2,6,7]. Only four report and compare findings from multiple sites[11,12,14,16], one of these a survey[12]. None of the studies were replications, and none are experimental.

Nevertheless, from this small beginning, we have learned important things about: the prevalence of the practice in acute and long term care; the natural history of restraint use in nursing homes; the characteristics of the restrained; risk factors for restraint; physical, psychologic, behavioral and mortality effects for patients; decision-making, rationale for restraint, beliefs and knowledge of alternatives of staff; and the context of restraint use in long term care. We have also learned that restraints are ineffective in preventing falls[14]. As a summary critique[19], the few studies which exist suffer from their descriptive and retrospective nature, limitations in sample size and selection method; and use of single institutions, usually the acute care hospital. Only a few support the iatrogenic physiologic or psychologic effects of restraint in a frail elderly population, or their effects on staff. None have compared the effectiveness of physical restraint vs. alternative interventions in relation to outcome measures. None have compared designs of the various restraint products in terms of safety, comfort or efficacy. There have been no prospective, controlled multi-site studies demonstrating the efficacy of a planned intervention in reducing restraint use in nursing homes. Thus, significant gaps exist.

Some say "Why do we need research on this problem? We already know that physical restraint has negative effects for frail older people." Yet many unanswered questions do remain, including whether restraints are bad for all older people in every circumstance. Further, knowing alone seldom leads to doing, as has been made clear by recent public health warnings to us regarding smoking, diet, and exercise. Thus, a complex phenomenon like restraint use with older people will not change on the basis of knowledge alone. Other motivators must be identified to facilitate change in individual and institutional behavior. Research can help us identify these factors.

The multifaceted nature (Figure 5) of the phenomenon should attract researchers from many fields including ethics, the social and psychological sciences, the clinical sciences, the humanities, political science and law. In fact, although restraint use is frequently laid at nursing's doorstep, the problem requires an interdisciplinary approach for its full understanding and resolution. Further, there are a plethora of theories from these other fields which may have utility in framing studies of elder restraint. These include sociological theories of systems, social roles or imprisonment; psychological theories of victimization, perception, learned helplessness, sadism, burnout, learning; biologic theories of stress, circadian rhythms or immobilization.

Take, for example, the **socio-cultural perspective**. We know very little about the context in which restraints are used. What stimulates, motivates, and supports the staff to prescribe and apply the devices? What effect do the devices have on others' perceptions of the resident? And how do these perceptions contribute to the further deterioration of the individual's function? What part do the physical environment, the institutional philosophy, or the facility's prior experiences with legal liability or regulatory sanctions play in their use? Are there differences in use depending on ethnicity, religious affiliation, payment status or other socio-cultural variables in particular facilities? What are the subjective experiences of patients, nurses and families regarding the use of physical restraint? What will be the effect on these same parties when restraints are less often used in a facility? Will all the outcomes necessarily be valued positively? If a culture which supports "safety at all costs," including widespread use of restraints, exists in some institutions, how might we initiate change toward a cultural value for individualized care? What would be effective incentives? Firmly entrenched beliefs, attitudes, habits, knowledge, and philosophies must be modified if lasting change is to be achieved.

A sociologist interested in social movements will find this current reform movement reminiscent of others in our not too distant past. Documenting the effects of events such as today's symposium, the restraint research initiatives of prominent foundations and institutes, the passage and implementation of the nursing home reform legislation in 1987 (OBRA), the work of the "radical flank" abolitionists, and outcomes of research will be very interesting to trace over time.

Historical perspective: In addition, we perhaps have much to learn from a careful study of the history of the last restraint reform movement. Such data could be brought to bear on today's work, in order to avoid the failures of that less-than-successful effort in American psychiatry.

Socio-political perspective: From the socio-political perspective, the question must be asked: Why does the United States stand alone among developed countries in widespread use of restraint with older people? Development of better quality of care measures for use in monitoring long term care regulations and studies of the effects of varying reimbursement systems on restraint use are also of interest.

Ethical: From an ethical perspective, the questions are many. Is beneficent restraint ever permissible and, if so, when? If persons with problematic behaviors are not restrained, what is the risk of violating others' rights in communal living situations? What are the relevant quality of life issues? Whose choice is the risk-taking anyway? How should informed consent for implementation or removal of restraint best be approached with frail elders?

Legal Perspective: To date, as we have heard, little systematic investigation exists concerning legal constraints on restraint-free care. This information is urgently needed. Development of a revised, and more appropriate, standard of care--based on research--is also essential.

Biological perspective: Studies in the biological sicences may also shed light on the issue of restraint. For example, a recently published study on circadian rhythms[20] indicated that, in hamsters, physical restraint during the normally active period of the day can, by itself, induce changes in the circadian clock. How might this finding help explain some of the behavioral effects of prolonged daytime restraint in older adults? For example, nursing home residents who were restrained during the day have been shown to be three times more likely than the non-restrained to exhibit sundown syndrome, or evening confusion.

Psychological perspective: Preliminary investigation indicates that even a short restraint experience may have lasting effects on self-esteem and self-image in older adults. Additionally, recent studies indicate that nursing home residents exhibit more agitated behaviors and engage in less social behavior when restrained[10,13,15]. There is a need for more systematic data regarding short and long-term sequelae of restraint in terms of psycological, cognitive, behavioral and emotional morbidity.

Clinical: Finally, from a practice perspective, several questions come to mind.

How do nurses and physicians decide to use or discontinue restraints?

Are there patients for whom physical restraints may be beneficial? If so, can a profile be developed?

How can the design of restraint products be improved to produce safe, more comfortable and less dehumanizing types of devices for those situations deemed appropriate for such intervention?

How could physical environments, equipment and furnishings be redesigned to facilitate comfort, function, and quality of life?

Is there any real distinction between "restraint" and "protective device" when the same garment serves both purposes: in terms of how perceived by resident, staff, significant others? in terms of physical and psychologic effects over time? in terms of ethical principles?

Since the three major reasons for which restraints are prescribed are risk of falling, interference with medical treatment, and control of disruptive behavior, support of current and ongoing research on these areas of problematic behavior is crucial. The NIH-spsonsored initiative on falls and frailty, and the several studies supported by the Alzheimer's Disease Association, the NIMH and others on various types of problematic behaviors including wandering, disruptive vocalizations, agitation, aggression/assaultiveness, and so forth, will add greatly to our understanding of these problems and suggest alternatives for prevention and management which do not include physical restraints.

We also need to know: How efficacious are these various alternatives to restraint for behavioral management in terms of such outcomes as cost, health state, functional status, and staff morale and turnover?

Only the "interference with medical treatment issue" has not been addressed, at least minimally, by research. Here we may draw on the expertise of the medical ethicists for assistance in understanding expression of choice in a demented older patient who continuously pulls out the NG tube, IV or catheter. Additionally, there is room for research to test alternate methods of treatment, camoflaging treatment sites and equipment, use of distraction, companions, and other interventions. To my knowledge, although clinical wisdom supports the use of alternatives, little in known about their relative efficacy.

Studies of change in practice behaviors suggests that restraint use depends less on number of staff, than on their type and mix, level of training, and knowledge, skill, and sensitivity in interacting with older adults. Studies evaluating these variables would be of great interest.

Finally, models for individualized care must be developed and tested.

The rising prevalence of physical restraint use with the institutionalized, frail elderly--unprecedented in the previous century--is one visible symbol of the failure to deliver quality care. Growing public awareness of this failure, in part, drives current interest in research in this area. We can expect increasing numbers of studies on the phenomenon to appear in the literature over the next five years. The movement toward reduced restraint use with older people must be a thoughtful one, informed and guided by research based-evidence of ineffectiveness and harms of restraints and utility of alternatives. Thus, much remains to be done.

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Item 9

TRANSITION TO RESTRAINT FREE CARE: A MODEL FOR CHANGE

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Jill A. Blakeslee, R.N., Director for Health Services
Beryl D. Goldman, R.N., Associate Director for Health Services
Dawn Papougenis, MBA,OTR, Project Coordinator
Curt A. Torell, Ph.D., Director of Education and Organizational Development

Untie the Elderly
The Kendal Corporation
P.O. Box 100
Kennett Square, PA 19348

Is the elimination of physical restraints in long term care possible? How can a nursing facility begin to remove restraining devices? A growing number of people recognize that physical restraints are damaging physically and emotionally as well as a dangerous violation of human rights and know better alternatives exist.[1,2] Yet, most American nursing homes use physical restraints. According to a recent Health Care Financing Administration (HCFA) report on state and federal licensure surveys of nursing facilities in the United States, 41.3% of the residents* are tied to their beds or chairs.[3] Furthermore, evidence suggests that once a resident is restrained, the individual will remain in restraints indefinitely or until death.[4]

Change in this standard of practice depends on breaking established myths and assumptions. Resistance to this change is supported by the following forces: 1) an over-protective concern for safety and injuries,[5,6] 2) a belief system entrenched in the training and practice of our caregivers,[7,8] 3) an accepted procedure for providing easier care to frail and/or confused elderly,[9] and 4) the litigious nature of our society.[10]

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*Resident - term used to refer to all people residing in a long term care facility. Terminology emphasizes the individual's health rather than sickness or a need for medical care.

Myths and Assumptions

In addressing the use of physical restraints, four basic myths and assumptions can be identified. **The first myth is the belief that restraints decrease falls and prevent injuries.** This is not true. In a comparative study conducted by TirLawyn (1986), non-restraining facilities experienced less injuries from falls (37.3%) than facilities that used restraints (50.6%).[11] According to a literature review completed by Evans and Strumpf, there is no scientific basis of support that physical restraints safeguard residents from injury.[12] Research conducted at State University of New York Buffalo (1986) indicated that restraint use is a poor measure for the prevention of falls in skilled nursing facilities.[13] The Sunshine Village Nursing Home in St. Petersburg, Florida reported that eighty-three percent of the falls that occurred during a 12 month period between 1987-'88 were among restrained residents.[14] A thirty percent reduction of falls was reported by Marie Boltz, Associate Director of Chandler Hall in Newtown, PA with the elimination of restraints since October 1988.[15]

The risk of death through strangulation or asphyxiation when using physical restraints should be the greater concern. An account in the Long Beach California Telegram Special Report (1987) provided a list of thirty seven United States and Canadian deaths directly attributed to restraint devices between 1980-1987 (taken from accounts in medical literature and from reports by doctors, medical examiners and others to the Food and Drug Administration and the U.S. Consumer Product Safety Commission).[16] In most cases, fatalities occurred when residents attempted to slip out of vest restraints and were strangled. On two occasions, individuals died in fires when they tried to free themselves by burning the restraining vests. These deaths represent only part of a largely hidden and ignored problem.

The second myth is that restraints are for the good of the resident. Studies indicate that immobilizing or restraining older people does result in chronic constipation, incontinence, pressure sores, loss of bone mass, muscle atrophy, decreased tone and strength, contractures, decreased ability to walk, and eventual invalidism.[17,18] Perceptual and behavioral responses noted with prolonged immobilization compound the physiological effects and may contribute to the disorganized behavior exhibited by many restrained residents.[19] Attempts to restrain a frightened, confused individual only increase feelings of panic and fear which can result in angry, belligerent or combative behaviors. Combined with the loss of dignity, withdrawal and other emotional problems, it is a tremendous price to pay for the prevention of a possible injury. In the words of the late Emily Wilson, a physician and resident of Kendal at Longwood, a continuing care retirement community, a restraint is "an insult to, an attack upon, the unique spirit of a human being; it treats him as less than human, it manipulates him, it destroys his self-respect."20 (E. Wilson: "The use of Physical Restraints in Nursing Homes" from Physical Restraints: A Dilemma in Long Term Care Symposium proceedings presented at the American Association of Homes for the Aging Annual Conference, New York, 1986.)

Restraints make caregiving more efficient and less worrisome for staff is the third common belief. They might serve as a short term solution; however, restraints actually create greater dependency and more custodial care. In fact, use of restraints within compliance of the Department of Health and Human Services' long term care guidelines requires an estimate of 4.58 hours/resident/day of staff coverage-as compared to the 2.7 hours/resident/day-that is typically provided in Pennsylvania nursing facilities. As stated in the John T. Posey Company Inservice Guide, "Restraints and/or safety devices can never be used as substitutes for good nursing care or as a staff convenience. Your patient, when restrained, actually requires extra nursing attention."21 (Posey Inservice Guide, p.1, 1983)

The dehumanizing effect restraints have on both the caregiver and the resident has a profound impact on the total caring process. Many times, staff become complacent about using them, believe they are necessary to manage residents and consequently use restraints as a means of control. A physical restraint is in direct conflict with the concept of autonomy, and its use undermines the ability to perceive and interact with the older person as an individual. The resident is reduced to an object that is controlled regardless of individual will, needs or wants.

The use of restraints also has a negative influence on the caregiving process by restricting creativity and individualized treatment. Delivery of care is less challenging and becomes a tedious routine-a potential for burnout and turnover. On the other hand, eliminating restraints has the potential for infusing a sense of challenge, creativity, compassion and sense of worth on the part of the caregiver.

The final myth is restraints prevent lawsuits and malpractice claims. As noted earlier, deaths directly attributed to restraints are not uncommon. The risk of liability for such claims as false imprisonment, assault, etc. or death through strangulation is much greater with the misuse of physical restraints.[22]

There are minimal U.S. court cases where lack of restraints is the basis of successful litigation. It is also important to note the trend is toward tighter regulation of restraint usage. In Ohio, Rhode Island and California, it is a felony to harm an elderly person through the use of physical restraints.[23]

In effecting a change to restraint free care in a nursing facility, education and communication are powerful strategies to overcome resistance. Application of Kurt Lewin's theory of change offers a framework in which a nursing facility can manage the transition to restraint free care. According to Lewin, successful change occurs over time and requires three phases: **unfreezing**, **changing** and **refreezing**.[24] The unfreezing phase represents a required first step in stimulating people to recognize the need to change. The focus is on motivating people to deal with the given problem. This is accomplished by increasing the pressures to change and by reducing the resistances to change (breaking established myths and assumptions). The second phase involves changing habits and learning new attitudes. Finally, the refreezing phase offers the necessary reinforcement to insure that the new attitudes, skills, knowledge or behavioral patterns are made permanent. It is critical to maintain the new "forces" in an equilibrium to prevent the organization from reverting to its previous level of performance.

The proposed model is based on the successful experience with a pilot program involving a free standing nursing home and a subsequent demonstration project with nine other long term care facilities to eliminate physical restraints in the care of residents. Lewin's theory of change provides the organizing framework for diagnosing the resistance to change and implementing the appropriate communication and education strategies for overcoming it. Particular attention is given to the three phases of the change process and the impact of the change strategies on the key groups of a nursing facility's organization.

Target Groups for Change

Within each long term care facility, six identifiable groups, with attitudes based upon their educational background, life experiences and perceptions, are targets for change. In order for the administrator and/or another key person to facilitate change and unfreeze the behaviors, these attitudes need to be recognized and confronted through rigorous communication and education. The following describes these groups and their attitudes regarding the use of physical restraints and the transition to restraint free care.

First, the board of directors is responsibile for setting policy. While board members have personal ideas and feelings regarding the care of the elderly, they expect the administrator and professionals of the organization to educate them about the actual day to day operations and the needs of residents and staff. Generally, board members perceive restraint use as the norm and a necessary, but unfortunate component of quality care. Unless members have had personal experience with a parent or spouse, they probably have not been effected by the pain and depression experienced when visiting a loved one who is restrained.

When the issue of eliminating restraints is presented to board members in educational sessions, specific concerns usually surface. On a philosophical level, boards are supportive of the concept and appreciate the opportunity to discuss it, however, a sense of caution predominates. Board members sight the need for further exploration in the areas of legal implications and practical management of "at risk" residents.

The administration of the facility represents the second key group to focus on when preparing for the change to restraint free care. This group falls into two primary categories: those who take a strong stand and advocate this change and those who take a less dominant position.

The next group, the physicians, present a unique perspective on the restraint issue. They have the ultimate responsibility of overseeing the care provided and are the only ones permitted to write orders for restraints. Moreover, they have minimal contact with the resident as compared to caregivers in the facility. The major concern expressed by physicians when broached with the topic is the myth that restraints prevent lawsuits and malpractice claims. Physicians generally believe their use is a necessary legal protection. Some of the physicians feel uncomfortable ordering restraints but are encouraged to do so by nursing staff requests when residents are falling out of chairs and beds and/or wandering out of the home.

Fourth, the nursing home staff have numerous concerns and beliefs that need to be expressed, such as resident safety and liability. Although many caregivers do not feel comfortable tying residents, they support the second myth by saying, "it's for their own good," and "they'll get hurt." A basic discomfort is acknowledged by some staff when they begin working in a long term care environment, but these feelings gradually decrease. Over time, it is as if staff no longer see the restraints and accept them as part of the environment. Staff assumes that restraints are the only alternative for managing residents, particularly those who are frail or confused. When confronted with the idea of eliminating restraints, a sense of defensiveness emerges. The concept of restraint free care challenges the quality of care currently delivered and threatens even the most caring of nursing staff. Staff frequently express the belief that restraints make daily working conditions easier and caregiving tasks less worrisome. Resistance is often couched in the arguments of staff shortage and overworked employees.

The residents themselves are another group with concerns and viewpoints around the issue. Primarily, the alert residents express concerns about wandering residents entering their rooms when not welcomed or going through their belongings without permission. Also some residents have had the experience of watching a spouse go through a period of falls and injuries and wonder if the risk of physical harm will increase with the elimination of restraints.

Finally, the family and friends who have struggled with the decision to place a loved one in the facility believe that the health care professionals have the expertise to provide quality care. Physical restraints are accepted as the standard of care and a necessary evil. Family members need to believe that the "professional" health care staff are providing the best possible care for their elderly family member.

Change Process

An administrator or a key person in the organization with the commitment and power to effect the change is essential for the transition to restraint free care. In addition, the support of another "transition" person with the determination and motivational skills to accomplish the goal is highly desirable. In many cases, this individual is a staff member and instrumental to a successful transition to a no restraints policy. This person can keep the momentum going and intercede quickly when specific challenging cases present themselves.

The initial challenge for the "transition" leaders is to "unfreeze" present behaviors and to change the attitudes of each target group. There is no one definite way to approach each group, except patience and time. In some organizations, one group may be the most resistant, while in another setting, it may be the most accepting and supportive. Adequate time must be allotted for each group to express apprehensions and misperceptions and to explore possible ways to introduce the change. The key is to know the individual issues of each group and be flexible when initiating a strategy for change. Educational programs and communication exchanges should be structured in ways that will address each group's respective concerns.

At the board level, a no restraints policy should be established before the program begins to alleviate confusion and fear on the part of staff. All levels of the organization should feel confident of the board's position and support on the issue. A formal presentation at a board meeting or a half to full day board retreat would enable board members to comprehend the issue fully and set the policy. Background materials should be provided prior to the meeting to increase board awareness of the topic and to stimulate questions and ideas. Depending on the composition of the board, sensitivity training through a basic simulation game, such as "Into Aging,"[25] could be incorporated in the education process to deepen an understanding of the aging process and the associated losses.

It is difficult in many situations to get the attention of the physicians, since their time in the facility is limited and the demands on them are great. Inviting them to a breakfast meeting has been helpful in some cases, but one should not be discouraged if the attendance is low. The meeting should discuss the newly approved board policy to eliminate physical restraints. Physicians not attending should receive: 1) the minutes of the meeting, 2) literature describing the legal risks and delineating the numerous deaths and injuries associated with physical restraints, and 3) the new policy and its effective date.

Residents and families also need extensive education and reassurance. The new policy should be introduced and discussed at resident and/or family meetings. Offering residents and family members sessions with the administrator and/or others to discuss specific residents is another helpful option.

Administration, including all department heads, must be informed of the plan prior to implementation. Although the nursing staff is the only discipline permitted to apply restraints, the concept of restraint free care effects every department. While all staff may not fully understand the issue initially, their support is vital.

An anonymous attitudinal survey serves as an effective "unfreezing" tool for all levels of staff to express concerns regarding physical restraints and to recognize the need to change. Our experience has shown that the survey provides a non-threatening vehicle for voicing apprehensions about eliminating restraints and increases an awareness to the damaging effects of restraints. Survey responses also provide a valuable resource for the change agents to identify areas of resistance within the organization and to plan accordingly.

Sensitivity sessions are another "unfreezing" technique since the staff are younger than the resident population and may not be able to identify with the changes and/or feelings that are experienced with aging. Attendance at inservices to explore alternatives to restraints, to strategize the process for restraint elimination and to individualize the care of each resident from a given resident should be encouraged. Staff and others need to understand that all restraints cannot be eliminated immediately, "cold turkey," but rather a slow, methodical system is employed where specific alternatives are gradually introduced.

Guidelines for the "change" phase are as follows:

1. Eliminate physical restraints on the easiest cases first, then gradually move towards the more difficult ones (as determined by staff). Achieving success with the easier ones encourages staff to continue efforts with the more challenging cases.
2. Prohibit application of restraints once they have been eliminated
3. Monitor use of medications. Chemical restraints are not used in lieu of physical restraints.
4. Look at each fall to see why it happened. Keep clear and accurate records.
5. Encourage creative problem solving sessions which involve all disciplines, i.e., social services, nursing, recreational, physical and occupational therapies, and other departments as needed.

6. Focus on the needs of the individual resident, not the convenience of staff. Similarly adapt the environment to the resident, not the resident to the environment.
7. Emphasize safety concerns: the elimination of physical restraints does not mean one forgets to provide a safe environment.
8. Develop protocol whereby physical restraints will not be used on new admissions.

Once the change process is initiated, the commitment to see it through to complete elimination must be continued. If exceptions are made, such as cases when restraints are re-applied to manage residents temporarily in "difficult periods," the change process will be undermined. The use of restraints will again increase over time and re-establish itself as the standard of care.

Throughout the change or transition phase, consistent positive reinforcement of the staff's accomplishments is necessary to encourage progress and to reaffirm the organization's commitment to the elimination of physical restraints. Routine team problem solving sessions as the response to managing challenging cases should be promoted by administration. At this point, a formal no restraints policy is essential to provide the necessary staff confidence in board and administration support. The policy should address the position of the facility on restraints in short-term emergency situations and outline the additional staff and physician responsibilities needed on such occasions.

Finally, the refreezing phase offers reinforcement to insure that new attitudes, skills, knowledge and behavioral patterns are made permanent. Physical restraints are completely eliminated and not considered an option. Creative alternatives and individualized care are the norm. Post interviews with staff; data collection on falls, injuries, incontinence, and bedsores; and on-going education are all strategies to maintain the facility's new level of performance.

Re-surveying of staff when the restraint use is reduced by 90 to 95 percent offers valuable insights with regard to current understanding, attitudes and creativity. A follow-up survey one to two years after the transition is also beneficial. Overall, responses from surveys of the demonstration project are positive and reinforce the basic belief that staff does not like to tie up old people. As stated by staff in a "transitioned" facility: "I wouldn't work any other place now. I wouldn't have said that or believed it two years ago"; or, "Now that I've seen the difference, I wouldn't want to work in a place that does"; or, "I like it, it kind of makes you proud."

Physical restraints in long term care settings can be replaced with restraint free care. Such a transition takes an organized, planned effort to change the attitudes, beliefs, practices and policies of a facility. The proposed model offers a systematic approach by which the transition can be achieved through the work of staff, boards, administration, residents and families.

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Item 10

AMERICAN JOURNAL OF NURSING

SPEAKING OUT

UNTIE THE ELDERLY

BY JILL A. BLAKESLEE

The number of falls or fractures is no greater when you set elderly patients free.

A lifetime ago, nursing students staffed the hospitals. Particularly at night, the only RN was the supervisor, whom we rarely saw after she made her rounds.

Often, I was assigned to wards filled with chronically ill older people. Since old people in a hospital get confused at night, many were routinely tied in their beds. The nights were noisy—until I discovered that if I removed their restraints, people usually slept soundly. Or, if they awakened, they liked to sit and chat or just watch the activity. Their nights—and mine—thus became much more pleasant.

My conviction that physical restraints destroy people and that we must find a better way to protect patients has been reinforced throughout my nursing career. When I worked with the mentally retarded, I encouraged staff to remove restraints and talk with hyperactive teenagers to figure out why the youngsters were upset. It wasn't easy, but neither is restraining people. After mentally retarded adolescents, I began to work with older people.

The restraint policy's effects on them were apparent. People who had walked into the facility on admission could barely walk to the bathroom with the assistance of two caregivers one month later. Remove their restraints? No! They might fall, break a hip, and we would be sued. We had rendered them helpless in 30 days and crippled them safely.

I am convinced it was a stroke of fate that I found a position in a continuing care community that was just about to open. The administrator and the board of directors were willing to support me in establishing a no-restraint program.

That facility now is 15 years old, and 11 years ago we opened another one. *We have never used a restraint or a gerichair in either facility.* Our records show that we have no more injuries from falls than do facilities that use restraints.

WHOM ARE WE HELPING?

Usually, restraints are used when a person is experiencing extreme emotional distress. In turn, not understanding why he is tied to his bed or chair, the person becomes anxious and pulls at the bonds. He calls out for help and his anxiety builds into terror, then anger. Caregivers, seeing this reaction, are convinced the restraints are necessary.

When the resident's protests do not bring freedom, his resistance often subsides because of sheer exhaustion, and resignation and withdrawal set in. The person detaches himself, intellectually and emotionally, and moves to a level of existence we have little hope of reaching. For his physical protection we have broken his spirit, the very spirit he needs for his rehabilitation.

Given the choice, would people want to be protected this way? Having lived to their eighth or ninth decade, they've taken many greater risks in their lives. Do we have the right to make this costly choice for them?

Whether restraints deter fractures, bruises, and lacerations is debatable. We know as fact, however, that restrained older people often do suffer from chronic constipation, incontinence, pressure sores, loss of bone mass, muscle tone, and the ability to walk independently. Combine these with their emotional problems and we can only conclude that, by restraining elderly people, we are asking them to pay a tremendous price to prevent a possible injury.

RATIONALIZING RESTRAINT

One reason I often hear for restraining a person is that the person is unsteady and frail

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Jill A. Blakeslee, RN, is director for health services at Kendal-Crosslands skilled nursing facilities in Kenneth Square PA.

and may fall. Instead of tying this person up, however, why not use physical therapy and other activities to improve muscle strength and to provide some mental stimulation in the process?

But if he falls, we may be sued, restraint defenders say. We couldn't, however, find any successful suits for not using restraints. We did, on the other hand, find successful suits for injuries resulting from the improper use of restraints.[1] Also we open ourselves to being sued for assault and false imprisonment when we tie up people without their permission.[2]

Without restraints it is true that the person may wander away from the facility. But it can be exciting for staff to match their creativity with a creative and resourceful resident who wanders. Some things that have worked for us are alarms on the wanderers' doors and the unit's exit doors. They needn't be expensive systems. Our maintenance staff created and installed our system.

For best results, ask staff to be responsible for the wandering resident only in small blocks of time. No one staff person can take this responsibility over an extended period of time. The task is too punishing. But everybody can do it for short periods.

Enlisting others helps. Everybody in every department needs to understand that wanderers *must* be on the move. All the staff, not just the nurses, should be aware of wandering residents so they can watch for them.

When a wanderer is determined to travel outside, don't try to change his mind. Walk with him, perhaps circle back, and, while you are doing that, try to determine where he wants to go and why he wants to go in that direction. Can you relieve his anxiety? Can you direct his intention elsewhere?

Another excuse for restraints is that without them the wanderer will go into other residents' rooms. We try to avoid this by making the confused resident's room easily recognizable, using photos, symbols, signs—whatever works—to direct him to his own room. We also try to help other residents understand, to be empathetic and helpful to the confused person, rather than frightened of him. Alert residents often are wary of the confused person because they fear that such confusion awaits them in their own future.

NO RESTRAINTS?

Do you practice in a facility that has a policy of NO PHYSICAL RESTRAINTS?

If yes, please tell us

Name of facility

City, State

Kind of facility (hospital, nursing home, psych, other)

Has the policy been in place more than five years? Less?

What is the most positive effect of a no-physical-restraint policy?

What is the most negative?

Please send your response to *No Restraints, AJN 555 W. 57th St., New York, NY 10019.*

"But," goes a common response, "we do not have enough staff to watch everyone." Restraints cause frustration, anxiety, fear, anger, and then lethargy. What's left is custodial care that always takes more time and is punishing, uninteresting work—and you'll never have enough staff! The challenge of solving care problems without resorting to restraints brings opportunities for creative care and happier staff.

Side rails, for instance, are useful to prevent a person's rolling out of bed or as grab rails for changing position. As long as side rails provide assistance and a sense of security to the resident, they are not restraints. But if they make the resident anxious, work out a solution. Try half-side rails that allow a person to get out of bed without having to climb over the rails, and lower the bed as close to the floor as possible. Try pinning the call bell to the resident's nightgown. When the call bell cord is stretched by an attempt to leave the bed, the plug comes out of the wall and the signal is activated. Sometimes putting the mattress on the floor works.

There is always a reason a resident does not sleep. He may be in pain, be anxious, have a full bladder, be constipated, have slept all day, gone to bed too early, be hungry, thirsty, or lonely. Find out and work to solve the problem. After all, how many of *us* sleep all night? Who says we must?

There is no single formula for handling each situation. Every frail, confused resident is an individual with his or her own agenda. The behavior must be studied, as well as the circumstances that bring on that behavior. Then, usually through trial and error, we look for a way to avoid or relieve the anxiety that is torturing the resident.

It has been easier for us to succeed with our policy of no restraints because we have had the policy since our facilities opened. It's more difficult to change an existing policy. The success others have had in abandoning physical restraints, however, can help. Refer to them when you begin educating your administrator and/or board.

You must have an administrator who is willing to support the staff through the tough times that are sure to occur. From there, you can work with physicians and other staff as well as residents and their families, case by case. Share their pride and their pleasure as they begin to succeed and to discover that untying the elderly is the better way. ☐

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Item 11

The Use of Physical Restraints in Nursing Homes

by

Emily T. Wilson

September 1986

I regret my inability to be present in person for this critically important consideration of the use of physical restraints in nursing homes, but I am grateful for the opportunity to introduce the subject via electronic devices. I have been asked to speak about the philosophical aspects of the problem from the point of view of a Kendal resident and a retired physician. For many years, I practiced medicine as a country doctor in northern Vermont, and later as a member of a mental health clinic in New Hampshire, working with the elderly.

Not long after joining the Kendal retirement community, I was a participant in a survey conducted by a young doctoral-degree candidate on the subject of Autonomy. Scores of residents cooperated in answering his extensive questionnaire and in the discussions that followed on the conclusions he reached in his thesis. From that time on, autonomy was the watchword at Kendal. All choices to be made were based on the individual's right to be heard, be it relative to attending a concert, going on a bus trip, or making the decision to move into the medical center. The individual was the arbiter, and had the inalienable right to participate in every important decision affecting his life. Needless to say, the administration had operated on this assumption from the beginning, but the results of the survey had made the residents aware of their responsibility for intelligent participation.

The use of physical restraints is in direct opposition to that principal. It is imposed upon confused, inarticulate, difficult people who are given no choice in the matter, but I think the whole problem goes beyond the concept of autonomy. Restraint is an insult to, an attack upon, the unique spirit of a human being; it treats him as less than human, it manipulates him, it destroys his self-respect.

There is, however, a greater issue at stake, beyond the questions of autonomy, and the insult to the essence of the person. In recent years medicine has made tremendous strides in technology and diagnosis and treatment, and we are all grateful for much of that, but there is one field that is still eluding us to a great degree and that is an understanding of what goes on in the human mind when the patient is apparently comatose, or otherwise unable or unwilling to communicate. The more I have observed such people, the more certain I am that something is going on, and we dare not forget that as we consider their treatment.

I would like to share with you some experiences that I believe have relevance here. In our nursing care facility, our residents are permitted to move about freely, regardless of the apparent clarity of their mental processes. One dear friend of mine, who made no effort to communicate verbally, spent considerable time each morning making the rounds of the corridors in the Central Reception area of our main building. She investigated every nook and cranny, opened table drawers, looked over files on the receptionist's desk, and carefully replaced them, all with quiet concentration. I often wondered what was motivating her. One day I mentioned this to a young man who had known her as the director of an excellent educational institution. He was not the least surprised. It seemed that each morning, during her active professional life, she had made a complete survey of the school property, satisfying herself that eveything in every room was in proper order. She was unable to handle her correspondence, of course, and could no longer read the cards and letters that occasionally arrived, and I was asked to help her with it. I never opened the envelopes, but handed them to her, telling her from whom they came. She followed a definite routine of carefully examining the sealed envelope, turning it over and over, then getting it open with a little encouragement from me, and finally removing the contents. When I suggested that I'd be glad to read it to her, another long routine ensued - putting the card back in the envelope, taking it out, turning it over, delaying as long as possible the time when she would hand it over to me. Eventually, I came to understand that this was her way of putting off my departure as long as she could. When I would finally say that I must leave, she would immediately thrust the missive into my hand, with a sly grin. She knew exactly the game she was playing. Dare we say we should have restricted her daily wanderings or denied her the pleasure of her devious way of prolonging a visit?

Another Kendal friend of mine had been a very active, involved person in her younger days - a beloved teacher, an avid mountain climber, a scientist who went out into the Pacific to witness an eclipse of the sun after she retired. As the years at Kendal went by, she gradually developed physical problems, decreased hearing, impaired vision, and severe arthritis which not only greatly restricted her activity and her enjoyment of life, but filled her with anger and resentment and made her very difficult to live with. Eventually she had a stroke which produced partial paralysis and many weeks of invalidism. She could talk, but refused to communicate with anyone. She lay in bed by the hour, her eyes closed, saying over and over again, "Oh dear - it's so hard - oh dear". One day, on her way back to her room from the hairdresser, she met me in her wheelchair in the corridor. She appeared happy and at peace. She looked directly at me and said, "I've decided to live a better life." That night she died. When I told a friend about it later, she related a similar experience. An elderly woman had been bed-ridden and uncommunicative for several months, when suddenly, one morning, she sat up in bed, looked directly at her astonished family and said, "Well, now I've got that settled," and fell back on her pillow and died.

There are so many unanswered questions -- why are some of us given more time to complete the dying process when others go peacefully in their sleep, or abruptly in an accident? No one knows, but I have come to believe that those who recieve the extra time, regardless of their physical or mental condition, need it to settle what Dr. Kubler-Ross calls their important unfinished business. They may be restless and difficult to handle, but they most certainly do not need the burden of adjusting to physical restraint during this period of critical spiritual searching. No one really knows, but because no one knows, no one should dare to interfere.

I will close with two quotations - one from a brief meditation on a part of the 24th Psalm, and the other from Shakespeare:

"The earth is the Lords and the fullness thereof, the world and they that dwell therein - not the few, not the gifted, not the specially chosen, but they, simply they who swell therein." -- "Who can say more than this rich praise, that you alone are you."

Emily Wilson, retired physician and resident of Kendal at Longwood, shared these comments at the American Association of Home for the Aging Annual Conference, New York, September 1986.

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